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## Promoting moral reasoning and ego development through the use of deliberate psychological education in family counseling

Esther Benoit

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PROMOTING MORAL REASONING AND EGO DEVELOPMENT THROUGH THE  
USE OF DELIBERATE PSYCHOLOGICAL EDUCATION IN FAMILY  
COUNSELING

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A Dissertation  
Presented to  
The Faculty of the School of Education  
The College of William and Mary in Virginia

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In Partial Fulfillment  
Of the Requirements for the Degree  
Doctor of Philosophy

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by  
Esther Benoit  
June 2009

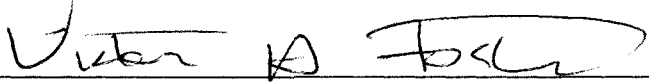
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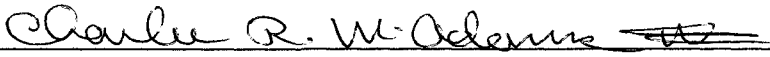
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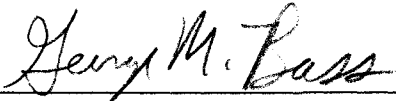
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For my Dad, whose faith in me inspired me to believe in myself  
I know you are with us still

Without the support of the following people, this dissertation would never have been  
possible.

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For reminding me to stay grounded and balanced  
For sacrificing so much for so long  
For encouraging, and loving me as deeply as you do  
Thank you, Jered

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For stealing my heart  
Thank you, Hazel

For your incredible courage, strength and wisdom  
Thank you, Mom

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Promoting Moral Reasoning and Ego Development through the use of Deliberate  
Psychological Education in Family Counseling

Abstract

Families come to therapy wanting to know how to raise good citizens and address issues of justice and fairness in the context of their interpersonal relationships. Research literature suggests that the family may be the best context for moral learning. The implications of deliberately promoted developmental growth within the context of a family therapy intervention are explored. Specifically, the relationships between moral reasoning, ego development and relational functioning in family therapy are examined within a systems-based therapeutic approach.

Outcome research in family therapy suggests that there is at least a moderate positive effect of family therapy. This study examines the effects of a deliberate psychological education (DPE) intervention in the context of systemic family therapy. This study proposed that those at higher levels of moral reasoning and ego development would exhibit a greater ability to adapt to normative family life cycle transitions and exhibit greater relational functioning as more cognitively complex parents may be better equipped to facilitate family organization, communication and emotional responsiveness.

Results of this study indicated developmental shifts in both the treatment and comparison groups over time, with significant positive gains indicated for the treatment group in the domains of ego development and moral reasoning. Family functioning improved slightly for the treatment group over time, but effects were not significant. Implications of this study and suggestions for future research are suggested.

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PROMOTING MORAL REASONING AND EGO DEVELOPMENT  
THROUGH THE USE OF DELIBERATE PSYCHOLOGICAL EDUCATION IN  
FAMILY COUNSELING

## *CHAPTER ONE*

### *Introduction*

This study considers the implications of deliberately promoted developmental growth within the context of family therapy intervention. Specifically, it examines the relationships between moral reasoning, ego development and relational functioning in family therapy. This chapter will provide an overview of the salient issues related to these topics, including contemporary challenges facing families and an overview of family counseling in the 21<sup>st</sup> century. The cognitive developmental paradigm is introduced as a framework for conceptualizing moral and ego development. Chapter two presents a selected review of relevant literature while chapter three describes the research design.

### *Statement of the Problem*

#### *Contemporary Challenges Facing Families*

The postmodern era brings with it acknowledgement that there are an “infinite variety of equally valid ways to view the world” (Mills & Sprenkle, 1995, p. 368). This poses unique challenges to families who find themselves in an increasingly complex world. While the challenges families face are not new, they are more and more demanding and sophisticated. Often, families bring these issues as their presenting problems when initiating family counseling. Many families find themselves struggling to thrive in an environment where fixed standards of right and wrong are no longer clearly laid out. Family values are now “less rooted in sacred principles of church and community than in a very private mix of personal situational beliefs” (Mills & Sprenkle,

1995, p. 368). Left to create their families based on personal beliefs, but within the context of pressure created by ever-present social norms, families often struggle to make sense of the complex demands of our post-modern world.

The family plays a prominent role during childhood, adolescence and into adulthood. It embodies our first social and relational experience and is the place where we learn to communicate and organize as systems. The institutions of marriage and family have acted as central organizing factors of society for centuries. Historically family life has been deeply gendered, and traditional family constellations have been favored both socially and politically (Thornton & Young-DeMarco, 2001). In recent decades, family life has shifted considerably. Where most relationships were based on family and kinship, increasingly, family members are engaged outside of the context of family. This shift outside of the family system demonstrates the emerging role of work, school and community as key organizing structures for individuals and families alike (Sprenkle & Bischof, 1994). In addition, culture, socio-economic status, education and other contextual variables influence how families and individuals come together. These issues do not exist in isolation; just as family systems are complex, the problems families face are multifaceted and interact with each other.

Following the 1960s, the United States saw a major shift in family beliefs and values about gender roles, marriage, divorce and other previously prescribed dimensions of family life (Thornton & Young-DeMarco, 2001). Along with a shift in beliefs about family life, the American family has also shifted in its composition. Divorce and remarriage are now considered normative family transitions and family constellations are ever more diverse (Sprenkle & Bischof, 1994). Various studies by the U.S. Census

Bureau have demonstrated these shifts in the structure and composition of the American family. The percentage of single-person households has grown dramatically. The nuclear family shrunk from 40 percent in 1970 to 25 percent of all households in 1996. In spite of this, the assumption that the nuclear family is necessary to raise well-adjusted children still prevails (Anderson, 1999). While the makeup of families in America has continued to change, public policy has often lagged in its support of multiple forms of families, leaving many of these families to fend for themselves in an often-unsympathetic social environment (Sprenkle & Bischof, 1994).

Families are changing in many ways. They are increasingly diverse with regard to their structures and our idea of what constitutes a family appears to be more open to interpretation and multiple perspectives than ever before (Mills & Sprenkle, 1995). Traditional ideas about family remain dominant, however, and a 2001 study by Thornton and Young-DeMarco suggested that “marriage and children are not only centrally significant and meaningful to the vast majority of Americans but may have become more desired and expected in recent decades” (p. 1030). Families are faced with the challenging task of making meaning of their increasingly demanding and complex lives in a society that sends conflicting messages about the nature of family life while offering little to no support or guidance for families in need. Families that present for counseling are frequently discouraged, disempowered and frustrated. These families often come to counseling because they believe (or someone has suggested to them) that they are somehow not “normal,” and that a problem exists within their family system that needs to be fixed. Family therapists work to support these families as they attempt to make sense of their struggles and explore alternative ways of interacting with each other. Given the tremendous challenges families today are faced with, long-term growth and change can seem a daunting, if not impossible task.

### *Family Counseling in the 21<sup>st</sup> Century*

Most theories of family therapy were developed as theories of modernism. Many are based in cybernetics and systems theory and have traditionally viewed families as entities that can be systematically analyzed and re-structured. This one-size fits all approach to counseling is no longer relevant in our pluralistic society (Nichols & Schwartz, 2001). Issues of race, class, cultural identity, sexual orientation and power challenge the traditional paradigms of counseling theory and practice. When one considers that "except for Virginia Satir, all of the prominent family therapy theorists of the 1960's and early 1970's were White, middleclass men" (Silverstein, 2003, p. 17) it becomes clear that many concepts within family therapy theory are permeated by dominant male values (May, 2001). Early family therapists emphasized the importance of families being self sufficient and independent, and de-emphasized the importance of connection and interdependency. Only recently has there been a call to explore the larger social context in which the family lives in order to evaluate what is considered normal in family development (Walsh, 2003). Constructivism, or the belief that individuals construct reality, helped to usher in the postmodern era and has shaped approaches to therapy. Postmodern approaches to family therapy focus on collaboration and more flexible and relevant ways of conceptualizing and helping today's diverse families.

Within many models of family therapy, emphasis is placed on how systems regulate themselves and the roles that family members play in this process of constant regulation (Mills & Sprenkle, 1995). Structural Family Therapy (SFT) is one model of family therapy that has been widely and successfully used with multistressed families. This model, developed by Salvador Minuchin, is predicated upon a systemic framework that

looks at individuals in a social and relational context (Vetere, 2001). Structural Family Therapy is a competence-based model that encourages families to explore the “edges of their known repertoires of responding, assuming that family members have the ability to innovate and draw on less tapped interpersonal and intrapersonal resources (Vetere, 2001, p. 134). Structural Family Therapy represents a “consciousness raising” model of therapy for families where intervention is promoted at three levels: challenging symptomatic behavior, family structure and belief systems (2001). The SFT approach is structured around three main concepts: family structure, subsystems and boundaries. Structure refers to the family’s organization including roles, rules and implicit assumptions about the family’s dynamics (Vetere, 2001). Subsystems include individuals and groups of individuals separated by gender, age, relationship or common interest. Boundaries refer to the family’s invisible lines of structure; these lines can be either rigid or diffuse and affect how family members interact with each other and with outside systems (Minuchin, 1974).

Postmodern therapies are primarily language focused (Mills & Sprenkle, 1995). These approaches contend that client change is facilitated through the language-based expression of meaning making systems. This focus on language and expression highlights the importance of client perspective within a postmodern approach to therapy. Structural family therapy has evolved from its original form and has come into its own as a postmodern approach to family counseling. Within the original Structural model, many of the poor families Minuchin worked with were seen as deficient because they depended on systems beyond their immediate family system for survival. Minuchin initially conceptualized families as natural organisms that need protection from social welfare and

mental health programs as these programs pose a threat to the individuality and personal integrity of the family system (Goldner, 1991). This emphasis on self-reliance was clearly constructed within the dominant discourse and devalued perspectives that consider mutuality and interconnectedness as valuable aspects of family life. Postmodern SFT emphasizes collaboration with family members and pays more explicit attention to culture and context as mediating factors in family life (Vetere, 2001). Many of the initial critiques of the SFT model have been addressed in its evolution to a more constructivist approach to client change (Mills & Sprenkle, 1995). Postmodern SFT offers a well-rounded approach to family therapy, one that has been empirically supported as useful with diverse and multi-challenged populations (Navarre, 1998).

While Postmodern SFT represents a considerably more contextually sensitive and collaborative approach to working with families than many traditionally conceptualized models of family therapy, it is not a perfect model. No model of therapy can claim to be completely comprehensive, as families and systems are too varied and complex to be explained by a single theory. Models of therapy provide frameworks from which therapists can conceptualize client struggles and plan treatment. The Postmodern SFT model acts as strong scaffolding for work with families; however, it does not specifically address developmental growth and change within the family system.

The importance of developmental growth is illuminated when one considers that cohesiveness and adaptability are vital elements of the family system. Families often find themselves renegotiating rules, roles and boundaries as they navigate and attempt to adapt to family lifecycle transitions. As families move forward, they are tasked with developing a balance between emotional connectedness and autonomy as family



members mature and move through these transitions (Vetere, 2001). This process of adapting and differentiating is often difficult for families and brings many families to counseling in the first place (2001). The longing for a sense of equilibrium or homeostasis within the family system is as constant as the ongoing transitions and changes in family life. The theories of cognitive development would suggest that the facilitation of developmental growth might be useful to families, as individuals at higher levels of development show increased flexibility and adaptability, qualities necessary for meeting the challenges of family life.

Postmodern SFT may help struggling families achieve some symptom relief, however it does not work to explicitly promote developmental growth (Crespi & Generali, 1995). A family's level of differentiation is seen as playing a "significant role in the family's ability to adapt to social and environmental changes, individual members developmental changes, and developmental changes for the family as a whole" (Andersen & Sabatelli, 1990, p. 34). Symptom relief may not be sufficient for today's multi-challenged families and a focus on longer-lasting change seems necessary. Postmodern theories of family therapy pay careful attention to collaboration and working *with* rather than working *on* families; however, these approaches to therapy are not without criticism. Critics contend that often, postmodern approaches, with their focus on language, are too abstract for some families (Cottrell & Boston, 2002). It seems that perhaps, a new approach is warranted, one that assists families in developing the tools necessary to take on the complex tasks of adaptation and differentiation.

Outcome research in family therapy has focused on how specific modalities of family therapy address various disorders. These disorders are often framed in an individual

context and include substance abuse, anorexia and conduct disorders. Previous outcome research included Structural Family Therapy in its evaluation of various treatment modalities. Sandberg et al. (1997) examined the effectiveness of eighteen models of family therapy with thirteen different disorders. Of the eighteen models studied only two, behavioral and structural, demonstrated effectiveness to be at least probable across a minimum of five disorders (1997). Nearly half of the models (8) reviewed were backed by one or no outcome studies. This study highlights the need for more outcome research in family therapy, but also lends empirical support to the use of Structural Family Therapy in treating various disorders from a systemic perspective.

Current outcome research focuses most heavily on the symptomatic domain of assessment. This may be, in part, due to the difficulty of measuring and assessing family interaction patterns. Various meta-analyses indicate that “most outcome studies in children and adolescents focus on this (symptomatic) domain and seek to measure symptom reduction in the identified child patient” (Cottrell & Boston, 2002, p. 577). The focus on symptom reduction in the outcome literature suggests that the symptom relief of the identified client rather than the change in overall family interaction patterns defines much of family therapy’s effectiveness. Although systemic theory posits that addressing family interaction patterns will produce lasting change, most outcome research specifically focuses on individual symptom relief (Carr, 2000). Long-term effects of family therapy have not been extensively studied. In the research conducted by Cottrell and Boston (2002), only nine of the reviewed studies included follow-up data with evidence suggesting that the positive effects of family therapy continued. These studies

also suggested that when positive effects were maintained, they were often diminished over time (Cottrell & Boston, 2002).

The relationship between evidence based practices and family therapy remains a tentative one, especially in a postmodern, constructivist era. Outcome based practices become increasingly difficult to quantify within the postmodern realm of family therapy. Forging a connection between outcome based practices and postmodern approaches to practice is not impossible, however; Carr (2000) advises that one must see the postmodern approach to practice as a “therapeutic positioning rather than a set of techniques” (p. 51). Commitment to constructivism as an overarching framework for practice is not mutually exclusive from a commitment to quantitative research and outcome research (Carr, 2000).

While some research has shown support for various models of family therapy in treating a variety of disorders, few studies in family therapy outcome research are of “sufficient methodological rigor to allow definitive statements about the efficacy or effectiveness of family therapy” (Cottrell & Boston, 2002, p. 578). Despite this relative lack of empirical support for many models of family therapy, there is sufficient evidence in the meta-analyses reviewed to support a moderate effect of family therapy both for symptomatic change and change in family interaction (Cottrell & Boston, 2002). This moderate effect must be considered in context, however, as it is greater when compared with no treatment versus compared with alternative treatments (2002). The current study seeks to investigate the effects of a family therapy model that includes a specific DPE component and structured session outlines. While the purpose of this study is to investigate the efficacy of this new approach to family therapy, it should be noted that the

treatment group in this study is compared with alternative treatment rather than no treatment. It was anticipated that this intervention would facilitate significant gains in moral reasoning, ego development and relational functioning as compared with a standardized postmodern SFT model.

Outcome research in family therapy suggests that there is at least a moderate positive effect of family therapy. The research literature has focused largely on the individual domain of symptom relief, which may be due in part to a health system that privileges individual problems and diagnoses (Carr, 2000). The primary focus on symptom relief in the outcome research literature is incongruent with the theoretical basis of systemic approaches, which suggest that long-lasting change occurs in the context of shifting family interaction patterns (Cottrell & Boston, 2002). Through this review of relevant outcome studies, it became clear that a new approach to family therapy was called for, one that integrates the support and collaboration of a postmodern family therapy framework with the adaptive flexibility of a developmental model. In developing this new approach, emphasis was placed not only on theoretically based assumptions about the nature of change, but also on evidence-based practice through the integration of an outcome measure that focuses on changing family interaction patterns.

### *Theoretical Rationale*

#### *Justification of a Cognitive Developmental Framework*

Cognitive developmental theory incorporates several theories that explain the development of the cognitive, internal structures that humans use to make sense of their environment. Individuals use these structures to both organize and adapt to their environments (Wadsworth, 1989). The model suggests that individuals develop

cognitively through a process of movement through sequential, hierarchical stages that progress in an invariant sequence (Sprinthall, 1978). These stages are a series of distinct and independent mental structures of increasingly complex meaning-making that enhance our capacity to gain mastery over ourselves and our environment (Sprinthall, Peace & Kennington, 1999). Several domains of cognitive developmental theory exist, as no one theory is comprehensive enough to describe the complexity of human functioning across all domains (Sprinthall, 1994). Cognitive developmental theory incorporates moral, ego, conceptual, and interpersonal domains of development. Each of these domains speaks to different parts of development; however, they share a core set of theoretically and empirically validated assumptions. These assumptions are based on three primary constructs conceptualized by Rest (1980): Structural organization, or how individuals make meaning of the world, the presence of an hierarchical and invariant developmental sequence, and interactionism- the notion that development depends on one's interaction with the surrounding environment.

The cognitive developmental framework represents a life-span approach, suggesting that people are capable of becoming more complex given an environment that facilitates such growth. "Growth does not take place automatically," and without significant events that encourage the shift from a lower stage to the next higher stage, stagnation occurs and individuals remain at stages below their developmental potential (Sprinthall, 1994, p. 189). This potential for growth suggests that an intervention for adults is not only possible, but recommended, given our relative preference for comfort in adulthood. Stages within the cognitive developmental model are conceptualized as current preferences that are open to change (Sprinthall, 1994), implying that change *can*

and *does* happen, and that growth and development are lifelong relational processes. The relational nature of development is particularly relevant to family therapy. Because development is relational, taking place in the social context, counseling, specifically, should create an environment for continued development (Hayes, 1994). Family therapy provides a unique environment for exploring development in its relational context as it encourages family members to engage with each other in challenging new ways. Making developmental growth a priority in our clinical work becomes important when we consider that higher levels of cognitive development are associated with more adequate meaning making structures that allow for increased flexibility and tolerance (McNeel, 1994). Increased flexibility and adaptability may buffer our clients against current and future life stressors, providing an additional level of support beyond that of the client-counselor relationship. Development becomes a critical component of counseling considering the complex challenges our clients face and the level of support needed to adapt and thrive in the face of these stressors.

If growth and development are our aim, we must first make the case for why higher stages of development are better. The assumption that higher is better does not mean that one is more intelligent or morally superior, but rather that one has “better conceptual tools for making sense of the world and deriving guides for decision making” (Rest & Narvaez, 1994, p. 17). The underlying assumption of cognitive developmental theory is that there exists a criterion of adequacy that distinguishes less adaptive from more adaptive (Lapsley, 2006). The goal of development is to attain a particular endpoint, which implies that higher is better. Developmental change is measured with reference to how closely it approximates the ideal equilibrium represented by the final stage of

development. “In this way, factual-empirical (what is the case) and evaluative-normative (what is good or ought to be the case) issues are always mutually implicated in developmental studies” (Lapsley. 2006, p. 40). If there exists (is) an endpoint or final stage of development, then we “ought” to be about promoting that more adequate structure of meaning making.

*The Use of the Deliberate Psychological Education Model (DPE)*

Promoting development becomes particularly important when one considers that most adults lack opportunities for the type of interactions that stimulate growth (Manners, Durkin & Nesdale, 2004). Psychological growth occurs when individuals are faced with challenging new experiences that create discomfort or disequilibrium. These experiences on their own are not sufficient, as development also requires a supportive environment and opportunities for guided reflection (Morgan, Morgan, Foster & Kolbert, 2000). The Deliberate Psychological Education (DPE) approach further expands upon this viewpoint in its assertion that “psychological growth does not occur automatically but must be stimulated, given an adequate learning environment that includes opportunities for role-taking, support, challenge and guided reflection” (Morgan, et. al., 2000, p. 206). The promotion of cognitive structural complexity does not naturally unfold; it must be carefully and deliberately facilitated (Sprinthall, 1984). The word “deliberate” advocates that we be intentional about our approach to promoting moral development. The Deliberate Psychological Education (DPE) model provides us with a structured set of necessary conditions that allow us to intentionally promote development.

Sprinthall and Mosher (1978) developed the Deliberate Psychological Education Model (DPE) as a framework for intentionally promoting cognitive development. Built upon the premise that developmental growth depends upon the quality of the interaction

between the person and the environment, this model sets forth specific criteria necessary in creating the ideal person-environment interaction. The DPE model assumes that certain conditions must exist for developmental growth to take place. These conditions include: a significant role taking experience as a helper, guided reflection, a balance between experience and reflection, continuity and an environment that is both supportive and challenging (Foster & McAdams, 1998). The DPE model has been successful in facilitating development across a variety of domains and with diverse populations (Faubert, Locke, Sprinthall & Howland, 1996; Morgan, Morgan, Foster & Kolbert, 2000; Royal & Baker, 2005).

#### *An Introduction to Moral and Ego Development*

Moral development as a domain of cognitive development is a psychological theory concerned with justice and fairness as they relate to moral decision-making. Moral development was adapted by Kohlberg (1969) from Piaget's earlier framework, and later critiqued and expanded upon by Neo-Kohlbergians such as Rest, Narvaez, Bebeau and Thoma (1994; 1999). The concept of moral development is particularly salient to family counseling as it represents a model of cognitive functioning that is the basis for conceptualizing issues of justice and fairness. Justice and fairness are important components of family functioning related to how families make meaning of their roles, rules and boundaries. Issues of justice and fairness in a moral development context have been linked to positive developmental outcomes in children. Parenting styles that emphasize Socratic dialogue and Kohlbergian higher-stage moral reasoning have been shown to be most effective (Walker & Hennig, 1999). In addition, children of parents who enforce moral rules and include their children in discussions about morality, justice and fairness have shown developmental gains (Leman, 2005). Walker and Hennigs'



research (1999) also indicates that parents' levels of moral reasoning and ego development are predictive of child moral development. Further support for working through parents to influence development in children is provided by Berkowitz and Grych (1998) who suggest "establishing a warm, mutually positive basis for interaction promotes the development of conscience and moral reasoning in children" (p. 383).

While families are not the sole source of influence on children's values, they are usually the first, and what is learned in the familial context often interacts with other major influences (Halstead, 1999). The work that can be done with families is crucial, given that there is a general perception of moral decline in society for which families are increasingly being blamed (1999, p. 266). At higher levels of moral reasoning individuals are better able to empathize, hold multiple perspectives and listen to others (Hayes, 1994). Working to promote the moral reasoning of parents seems especially important given their strong influence on the development of their children (Leman, 2005).

Most of the research literature on parental influences on children's morality has focused on three parent variables that account for the development of moral reasoning in children: family communication patterns, parenting style and parental stage of moral reasoning (Berkowitz & Grych, 1998). Authoritative parenting styles and clear, open family communication have been found to positively support children's development of moral reasoning. Furthermore, moral development and its focus on issues of justice and fairness also has implications for collaborating with outside systems such as schools and other mental health agencies. Modeling collaboration and the ability to take multiple perspectives within counseling sessions might help facilitate greater cooperation and collaboration with systems that have traditionally struggled to connect with families.

Where moral reasoning focuses specifically on issues of justice and fairness, ego development is concerned with interpersonal cognitive styles and how individuals make meaning of and come to integrate views of self, others, and self in relation to others (Hauser, 1991). The theory of ego development, developed by Loevinger (1976), exists along a continuum that spans impulsivity, manipulation, conformity, autonomy and interdependence. Ego development has been described as particularly salient to family therapy given its emphasis on relational processes (Krumpe, 2002). This is evidenced by its application to interpersonal relationships; at higher levels of ego development individuals exhibit greater ability to nurture, are more responsible, exhibit greater self-control and place more value on individuality (Hauser, Gerber & Allen, 1998). The increased ability to nurture seems particularly relevant in justifying the use of ego development within a family counseling framework. Noam (1998) and others have explored how ego development relates to the theory and treatment of mental health issues, and parental ego development levels have been shown to be predictive of adolescent ego development. Not only has ego development been linked to adolescent developmental outcomes, it also suggests the potential to change and adapt in the face of normative life stressors (Hauser, Gerber & Allen, 1998).

#### *Justification for the Study*

Ego development focuses on interpersonal relationships and increasing interdependence; both critical for developing positive relationships within the family and between families and outside systems such as schools. Moral development emphasizes issues of macromorality, justice and fairness, equally important components of family life, but, however, quite different from the interpersonal, and largely more “care”

oriented, focus of ego development. Previous literature has focused on these domains of cognitive development and their impact on parenting and child outcomes. While the research suggests that both ego and moral development have strong implications for both parenting and child developmental outcomes, little to no research has been conducted with clinical samples of families. Most families represented in the research literature were recruited through school systems and were not actively seeking support or mental health services. Few studies have been conducted with clinically referred families. Those studies that have focused on clinical populations have generally focused on clinical samples of children.

Families come to therapy wanting to know how to raise good citizens and address issues of justice and fairness in the context of their interpersonal relationships. The unique struggles present for many of these families may influence their susceptibility to family-based developmental interventions. Issues of justice, fairness and interpersonal connection may be more pronounced for families who are in the position of seeking or being referred for additional support. In addition, the research literature suggests that the family may be the best context for moral learning as it provides:

a secure framework in terms of group identity; it satisfies the need for a personal identity in terms of feeling confident, successful, useful and wanted; it puts the child in close personal contact with adults who provide authority figures; it provides opportunities for cooperation, participation, and living with others, and it provides satisfaction of the desire for intimate response and the approval of one's kind. (Halstead, 1999, p. 272)

Further research is needed to explore the impact of developmentally based interventions on clinical samples.

### *Purpose of the Study*

The purpose of this study was to integrate a cognitive-developmental approach with family therapy to promote the moral reasoning and ego development of a clinical sample of families in counseling. This study sought to explore whether a deliberate psychological education intervention in the context of family therapy could be effective in promoting gains in moral reasoning and ego development. This study also examined whether differences in moral reasoning and ego development were related to relational functioning in the family. This researcher proposed that those parents at higher levels of moral reasoning and ego development would be rated more positively with regard to their family's relational functioning and would demonstrate a greater ability to adapt to normative family life cycle transitions. This researcher hypothesized that more cognitively complex parents may be better equipped to facilitate family organization, communication and emotional responsiveness. Specifically, the purpose of the current study was to answer the following questions:

1. What is the effect of a DPE intervention on the moral reasoning and ego development of families in counseling?
2. What is the relationship between parents' stage of moral development and their relational functioning?
3. What is the relationship between parents' level of ego development and their relational functioning?

4. What is the relationship between parents' levels of ego development and moral reasoning?

#### *Definition of Terms*

Structural Family Therapy: (SFT) A theory of family counseling developed by Salvador Minuchin which emphasizes family structure, boundaries, subsystems and hierarchy. A manualized version of SFT was be used for the purposes of this study.

Moral development: A cognitive developmental theory developed by Lawrence Kohlberg and later expanded upon by James Rest and others, that describes how individuals think about issues of justice and fairness along a continuum of hierarchical stages, with higher stages indicating a principled perspective.

Ego development: A cognitive developmental theory developed by Jane Loevinger that describes individuals as progressing through stages of development along a continuum that spans impulsivity, manipulation, conformity, autonomy and interdependence.

Deliberate psychological education (DPE): A cognitive-developmental approach to intervention which includes: a significant role taking experience as a helper, guided reflection, a balance between experience and reflection, continuity and an environment that is both supportive and challenging (Foster & McAdams, 1998) This approach was integrated with the traditional model of Structural Family Therapy used at New Horizons Family Counseling Center.

#### *General Research Hypotheses*

This study was developed to understand the relationship between a developmental intervention based on the deliberate psychological education (DPE) model, and

growth in moral reasoning and ego development of parents participating in this study. As a result of the intervention, it was expected that parents receiving the developmental treatment would obtain significantly higher post-test scores on the DIT-2 and the WUSCT, and higher post-test ratings on the Global Assessment of Relational Functioning (GARF) than the comparison group that did not receive the treatment. Correlational analyses examining the relationship between parents' moral development levels, ego development levels, and relational functioning ratings were conducted.

### *Hypotheses*

- I. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in moral development as measured by the Defining Issues Test (DIT-2) when compared with parents of families receiving SFT alone.
- II. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in ego development as measured by the Washington University Sentence Completion Test (WUSCT) when compared with parents of families receiving SFT alone.
- III. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in relational functioning as measured by the Global Assessment of Relational Functioning when compared with parents of families receiving SFT alone.

### *Sample Description and Data Gathering Procedures*

The initial sample included 39 families referred to receive services at New Horizons Family Counseling Center. Attrition is expected in research projects, but the threat was amplified in this research project as it involved a clinical sample (Ward & McCollum, 2005). Due to the expectation of significant attrition, forty families were recruited with the hopes of establishing a sample of at least  $N = 30$  participants. Twenty families were assigned to each group and additional families were randomly assigned to each group as needed to address families who dropped out of the study before attending their first session. After accounting for families that terminated before attending their first session of counseling, the initial pretest samples included 20 families in the treatment group and 19 families in the comparison group. The final sample included 11 families in the treatment group and 11 families in the comparison group who completed both pre and post tests. The total number of families in this study was  $N = 22$ , and the total number of participant parents was  $N = 29$ . Both single and two-parent families were recruited, and both parents were assessed throughout the study. Participants were pre-tested on all measures during their first counseling session beginning in August 2008. Participants were post-tested after 10 sessions, or during their final (termination) counseling session, whichever came first. Demographic data was collected on all participants and is summarized in chapter five.

### *Limitations of the Study*

The major limitations of this study are related to the small, select, non-random sample of families referred for counseling services at New Horizons Family Counseling Center at the College of William and Mary in Williamsburg, Virginia. Families who are

referred to counseling through the local school system may be significantly different from families referred to counseling through other referral sources. Treatment fidelity poses a significant risk to the generalizability of this study's results. Careful attention to detail was taken in outlining the intervention to attend to treatment fidelity. Ensuring that each counselor facilitated sessions in a consistent manner was a component of the intervention; however, treatment fidelity remains a liability. Experimenter effects in the form of individual counselor effects also threaten this study's external validity. Counselors were assigned families in both the treatment and control conditions to counter any possible experimenter effects. Enough counselors participated in this study (ten) so that no one counselor had a large enough clientele to skew the data.

Social desirability effects may limit the results of this study as participants' knowledge that they were involved in a research study might have influenced how they responded to pre and post-test measures. Since the pre and post-test measures are identical, a possible risk for pre-test sensitization exists. The Global Assessment of Relational Functioning (GARF) used in this study is a therapist-rated measure, posing an additional threat to external validity since previous research has demonstrated that therapists may underestimate their clients' progress in family therapy (Ward & McCollum, 2005). Time constraints act as an additional limitation on this study, as ten sessions may not be enough for significant developmental change to occur. Decalage may occur when individuals appear to be functioning at a lower stage than their actual modal stage due to the sensitivity and vulnerability of the experience of being in counseling, and thus may also impact results. Each of these limitations is discussed in further detail in chapter six.



### *Summary*

This chapter presented an overview of the current issues relevant to families and their implications on the application of a cognitive-developmental intervention in the context of family therapy. The theoretical rationale for incorporating moral and ego development and a deliberate psychological education approach were presented. The research design was outlined in this chapter including operational definitions, expected study results, general sample characteristics and data collection procedures as well as some limitations posed by the research design. Chapter two includes a selected review of the literature relevant to this study.

## *CHAPTER TWO*

### *Review of Current Literature*

This chapter will review literature related to the theoretical constructs of moral and ego development. In addition, it will present relevant research related to the domains of moral and ego development in the context of family life. Finally, implications of the current literature will be examined with reference to their application to the justification for and design of this study.

### *Moral Development*

Kohlberg set out to reject ethical relativism and to demonstrate that a universal morality was possible if one focused on structures of meaning making rather than on the content of moral issues (Lapsley, 2006). Kohlberg believed that consensus on moral issues was possible if individuals were motivated by a “moral point of view” (p. 45). The structure and cultural relevance of Kohlberg’s theory have been challenged and expanded upon by Gilligan and Neo-Kohlbergians such as Rest and Narvaez. In Rest’s conceptualization of the psychology of morality, moral judgment is but one component among four (Rest, Narvaez, Bebeau & Thoma, 1999). While Kohlberg and Rest agree that moral judgment is only a part of morality, their consensus extends to the belief that moral judgment is not only an essential component of morality, but one that can and should be promoted in diverse educational and therapeutic settings. This table represents Kohlberg’s six stages that were later revised as the sixth stage occurred so rarely that there were no methods of scoring it using Kohlberg’s Moral Judgment Interview (Colby & Kohlberg, 1987; Rest, 1994). In Rest’s Neo-Kohlbergian work on morality, Kohlberg’s

fifth and sixth stages were combined as components of principled reasoning. Kohlberg's six stages are outlined below (see Table 2.1).

Table 2.1

**Six Stages in the Concept of Cooperation**

Stage 1	The morality of obedience: Do what you're told
Stage 2	The morality of instrumental egoism and simple exchange: Let's make a deal
Stage 3	The morality of interpersonal concordance: Be Considerate, nice and kind: you'll make friends
Stage 4	The morality of law and duty to the social order: everyone in society is obligated to and protected by the law
Stage 5	The morality of consensus-building procedures: You are obligated by the arrangements that are agreed to by due process procedures
Stage 6	The morality of non-arbitrary social cooperation: Morality is defined by how rational and impartial people would ideally organize cooperation

*Adapted from Rest (1994, p. 5)*

Rest's Four Component Model includes three additional aspects of morality that appear to address many of the arguments levied against Kohlberg. This Four Component Model suggests that moral judgment plays an important role in influencing moral behavior but that it is not the whole of morality (Rest, Narvaez, Bebeau & Thoma, 1999). The following table delineates Rest's Four Component Model (see Table 2.2).

Table 2.2

**Four Psychological Components Determining Moral Behavior**

Moral Sensitivity	Interpreting the situation
Moral Judgment	Judging which action is morally right/wrong
Moral Motivation	Prioritizing moral values relative to other values
Moral character	Having courage, persisting, overcoming distractions, implementing skills

Adapted from Rest (1994, p. 23).

Gilligan took issue with Kohlberg's theory claiming that it was biased against women in that it favored an ethic of justice over an ethic of care (Walker, 2006). Kohlberg focused on issues of macromorality, "advocating loyalty to abstractions over loyalty to persons" (Rest et. al, 1999, p. 5). The moral orientations of justice and care were seen as distinct and gender-related; however, Gilligan emphasized that they were not gender specific (Walker, 2006). While Gilligan's concerns about Kohlberg's model could not be substantiated empirically, her assertions of gender bias contributed to a growing awareness that Kohlberg's theory of justice reasoning was not all there was to moral psychology (2006).

Gilligan's critique of Kohlberg appears to polarize morality into an either/or rather than a both/and paradigm. This dichotomization has powerful implications for the cultural relevance of moral development. If one views moral development as promoting either justice *or* care, either macromorality *or* micromorality, then this process is indeed one that is not open to the multiple perspectives of those in non-dominant groups. Openness to multiple perspectives is critical in any approach to therapy, but is made even more important within the context of the developmental nature of family struggles. Rest's model includes components of moral sensitivity, moral motivation and moral character

that appear to address the claims that morality is not unidimensional but rather has both interpersonal and intrapersonal components. (Rest et. al, 1999, Walker, 2006). This Neo-Kohlbergian both/and approach to morality recognizes the value in Kohlberg's theory and expands upon it by exploring issues of content, culture, context and new ideas about moral relativity (Rest et. al, 1999). Kohlberg suggests that structures of reasoning or *structures d'ensemble* are universal while Rest contends that "morality is not a separate matter from social organization and group consensus" (1999, p. 28). To be culturally relevant we must eschew the conventional ethic of justice that is "undergirded by an assumption of universality without consideration of specific contextual differences" (Obidah, Jackson-Minot, Monroe & Williams, 2004, p. 119). Promoting culturally relevant moral development requires that we blend structure *and* content, justice *and* care (Obidah et. al, 2004). For the purpose of this research, moral development is framed within this *both/and* context.

#### *Moral Development and Families*

Research has shown that higher levels of moral judgment promote greater levels of social cooperation and understanding of self in relation to others (Rest et al., 1999). Through the process of promoting disequilibrium in an intentional, supportive and reflective environment we help others learn to begin to take the perspectives of others within varied contexts. This focus on encouraging perspective taking is particularly important given the complex challenges families face. Facilitating moral development encourages "simultaneous commitment to one's own world view and openness to other perspectives" (McNeel, 1994, p. 29). This openness to other perspectives can generate the capacity for more flexible and tolerant understanding of others and may lead to more

adequate interactions among family members as well as individuals outside the family system.

Previous research on moral development and families has tended to overlook the potential impact of parents as agents in their children's moral development (Walker & Hennig, 1999). Walker and Hennig (1999) conducted two studies that examined the role of parenting style in children's moral reasoning development. In the first study, they looked at children (ages 6-16) and their parents participating in real-life moral dilemma discussions. Parent behavior was coded and used to predict children's moral development over a two year long interval. In this first study only two parent families were recruited. In the second study, parent and child dyads were examined (both single and two parent, however, only one parent was recruited in two parent families). Parent behavior was again coded to predict the children's moral development over a longitudinal interval. These studies found that "the nature of parents' interactions, ego functioning and moral reasoning are predictive of children's moral development" (Walker & Hennig, 1999, p. 370). The findings also lead to conclusions about which parenting styles were most conducive to children's moral development. The most facilitative parenting styles were "encapsulated as involving supportive, Socratic dialogue and Kohlbergian higher-stage moral reasoning" (Walker & Hennig, 1999, p. 366).

A similar study was conducted by Palmer and Hollin (2001) that examined the relationships between perceived parenting, sociomoral reasoning and self-reported delinquency in a sample of high school adolescents. The participants in this study were 94 individuals between 12 and 18 years who volunteered to be part of the study. The sample consisted of 28 males and 66 females. This study used a convenience sample of

accessible participants sampled from schools in the West Midlands area of England. A warm, inductive and involved style of parenting was negatively related to delinquency and a parenting style characterized by physical punishment was positively related to delinquency (Palmer & Hollin, 2001). “One of the most consistent (and least anticipated) findings from research examining the family interactions that facilitate Kohlbergian moral reasoning stages is that the affective components of those interactions, such as parental warmth, involvement and support, are related to moral reasoning development” (Smetana, 1999, p. 315).

The study used the Sociomoral Reflection Measure- Short Form (SRM-SF) (Gibbs et al., 1992). The SRM-SF is a production rather than a recognition measure of moral reasoning that does not involve moral dilemmas. The measure is said to be similar to the Moral Judgment Inventory (MJJ) (Colby & Kohlberg, 1987). It has shown acceptable levels of test-retest reliability ( $r$  levels of .88 and above) and validity (SRM-SF and MJJ,  $r = 0.69$ ). Perception of parenting was measured using a self-report scale designed by Krohn et al. (1992) for use in the Program of Research on the Causes and Correlates of Delinquency. This instrument is a 5-point Likert scale used to measure respondents' perceptions of parenting. Self-reported delinquency was measured using Elliott and Ageton's (1980) self-report scale that looks at offenses committed in the past year. The SRMS shows high test-retest reliability ( $r = 0.70-0.95$ ). All participants completed all three measures in the following order: SRM-SF, Perceptions of parenting and Self-Reported Delinquency (SRD).

Results of Palmer and Hollin's study indicated a number of significant inter-scale correlations between the eight parenting scales. A principal component factor analysis

was carried out that found two factors accounting for 58.6% of the variance in the scores. The two factors identified describe two different components of parenting behavior. Factor 1 describes a parental style that is loving, involved and uses consistent and inductive discipline techniques where Factor 2 describes a harsh, cold disciplinary style of parenting. Females scored significantly higher than males on SRMS and on global moral stage. Stepwise multiple regressions were conducted to see which variables best predicted the three SRD scores. Supervision, age and positive parenting were found to predict SRD scores. Pearson's correlations showed that Factor 1 scores were negatively significantly associated with SRD, and that SRD scores were significantly related to Factor 2 scores. No significant correlations were formed between the factor scores and the moral reasoning variables. Unlike previous research, no relationship was found between socioeconomic status and perceived parenting. One potential limitation of this study is that IQ was not controlled for, since previous researchers have suggested that moral reasoning may be influenced by IQ and low IQ levels have also been associated with delinquency.

High scores on the self-reported delinquency measure were also associated with lower levels of moral reasoning. One of the major limitations of this study is its use of self-report measures. Children's perceptions of their parenting are likely to be quite different from that of parental perceptions or even objective observers. Perceptions of parenting may not always be accurate matches to what is going on at home in real life situations, and these perceptions may change as children mature. Self-reported delinquency measures also pose particular methodological challenges as one cannot be certain whether participants are likely to under or over-report their delinquent behavior.



Palmer and Hollin's study suggests that a parental style incorporating high levels of supervision enables consistent disciplinary practices to be maintained that together with high involvement promotes attachment between parents and children. A warm, inductive and involved style of parenting was negatively related to delinquency and a parenting style characterized by physical punishment was positively related to delinquency (Palmer & Hollin, 2001). The results of this study indicate that moral reasoning is facilitated by a style of parenting characterized by low parental involvement and parent-child attachment. High levels of harsh, cold and physical punishment were also associated with poor moral reasoning. An unexpected finding suggested that high levels of attachment, involvement and supervision in adolescence can lead to an enmeshed style of family interaction which the adolescent may rebel against. Further research is needed to explore the relationship between these variables. The research literature strongly supports the important role that parents play in promoting development within families.

Richardson, Foster and McAdams (1998) conducted a study that examined the relationship between moral development and treatment foster parent attitudes. This exploratory and descriptive correlational study focused on therapeutic foster care that combined family foster care with residential treatment. The foster parents in the study were professionalized and expected to function as part of a therapeutic treatment team to provide rehabilitative services to foster children. Participants included 103 foster parents who were certified as treatment foster parents through a child-placing agency in Virginia. All participants volunteered to be part of the study. This study used convenience sampling; however, the sample was carefully described as being demographically similar

to general profiles for treatment foster parents. The sample included 40 African American women, 25 White women, 23 African-American men, and 15 White men ranging in age from 27-76 years with a mean age of 44.5 years.

The Defining Issues Test (DIT) (Rest, 1979) and the Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1984) were used to assess the participants' levels of cognitive development and parenting effectiveness. The DIT is an instrument used to assess levels of cognitive development within the moral domain. It has internal consistency coefficients ranging from .74 to .85. The short form of the DIT was used in this study to comply with agency time constraints and to reduce the possibility of reactive testing effects. The shortened version has shown correlations with the original versions ranging from .91 to .93. The AAPI is an inventory that assesses parenting and child-rearing strengths and weaknesses. The AAPI does not yield a composite score, but rather four separate parenting constructs ranging from one to 50 with higher scores indicating more positive parenting attitudes. Test-retest and internal consistency measures have shown reliability coefficients equal to or greater than .76 for each of the four constructs. The study was both exploratory and descriptive and used correlational comparisons between each of the identified variables and demographic factors. Pearson Product-Moment correlational analyses were used with alpha set at .05.

Significant positive correlations were found between DIT scores and scores on three of the four AAPI constructs: Empathy, Disapproval of Corporal Punishment, and Lack of Family Role-Reversal (role clarity). No significant relationship was found between DIT scores and those on the Appropriate Parental Expectations construct in the AAPI. Moral development as measured by the DIT was also significantly correlated with

education and gender; female participants and participants with more formal education scored higher on the DIT. Parenting attitudes as measured by the AAPI were significantly correlated with gender, education and age. A significant relationship was found between education and the AAPI variables of Empathy and Lack of Role Reversal: parents with more education indicated more empathic parenting attitudes and less likelihood of inappropriately reversing parent-child roles. An unanticipated inverse relationship was found between age and the AAPI variables of Empathy and Role Reversal with younger participants showing stronger indicators of empathic parenting attitudes and appropriate differentiation between their own needs and the needs of the children in their care.

The mean DIT P score for participants in this study was substantially below the mean reported for the general adult population and was closest to that reported for high school seniors. The participant group's level of formal education may be the best explanation for this finding.

This study uses a correlational design, which is useful in the early stages of investigating possible relationships among variables. The results of this study must be considered with reference to the magnitude of the correlation coefficients with reference to other factors that might influence the findings. This study lends support to the application of a cognitive developmental framework to the design of training models to promote psychological growth and skill acquisition in treatment foster parents. In addition, this study indicates empirical support for the relationship between parent development levels and effective parenting constructs such as empathy, lack of role reversal and disapproval of corporal punishment.

Hoffman and Salzstein (1967) conducted a study that examined several dimensions of moral development in 7<sup>th</sup> grade children as they related to parental discipline. Discipline techniques were coded into three categories; power assertion, love withdrawal and induction. The study controlled for IQ and analyzed data separately based on social class status. The sample in this study included children in the 7<sup>th</sup> grade in the Detroit metropolitan area. Initially data were obtained from over 800 children; however, the researchers were unable to obtain reports of parental discipline from a quarter of those individuals. Parents of middle-class families were interviewed, but no lower-class parents were interviewed. The final sample included 444 children; 146 middle class boys, 124 middle class girls, 91 lower class boys and 83 lower class girls. The battery of tests was administered to groups of children in the schools during three sessions spaced about a week apart. Advanced development along the dimensions of moral development was associated with infrequent use of power assertion and frequent use of induction in the middle-class sample. Love withdrawal was inversely related to moral development. This study looked only at children living in intact two-parent households. Children identified by the schools as behavior problems and those in non-intact families were screened out. This limits the generalizability of this study considerably.

Janssens and Dekovic (1997) looked at the relationship between child rearing, prosocial moral reasoning and prosocial behavior. The researchers studied 125 children between 6-11 years of age and both of their parents. The participants were recruited from 22 elementary schools in the Netherlands and those participating were considered highly educated with 43% of fathers and 30% of mothers having finished vocational school or university. Prosocial behavior was measured using Weir and Duveen's Prosocial

Behavior Questionnaire (PBQ) (Weir & Duveen, 1981), which was given to teachers of the participating students. A second measure of prosocial behavior involved asking classmates of the participants the question "Name three children in your class who helped the most other children." The number of nominations received for each child was computed and divided by the number of students in the class. The correlation between the two measures was moderate ( $r = .29$ ;  $P < .05$ ) so the two measures were not combined in a composite score. Prosocial moral reasoning was measured using three stories by Eisenberg-Berg and Hand (1979). These stories each contained a dilemma between the needs and wants of the stories' main characters and those of a needy other. Interviewers read each story to the participating children and then asked the children what the story character should do and why. Scores were given based on the responses each child gave to the interviewer with higher scores indicating higher levels of reasoning. Child-rearing behavior was measured by both observation and interview data. Interviews were conducted at the participants' homes where family background information was obtained. The family was also observed while working on a social interaction task, followed by an individual interview with each parent. The interviews and observations were tape-recorded and later transcribed and coded. The unit of analysis was parental utterance directed at the child.

The final data analysis included a 3 (grade level) x 2 (sex of child) multivariate analysis. No significant main or interaction effects of grade, sex of child and sex of parent on child rearing were found. The effects of grade and sex of child on prosocial development were small. Correlations were computed between the indices of prosocial behavior and prosocial moral reasoning. Both indices of prosocial behavior were found to

be positively related to the level of moral reasoning. Correlations were computed between prosocial development and child rearing which demonstrated that a “supportive, authoritative and less restrictive child-rearing style was associated with a higher level of reasoning about prosocial moral dilemmas and with more prosocial behavior” (Janssens & Dekovic, 1997, p. 521). For the overall sample, moderate but significant positive correlations were found between the level of prosocial behavior and prosocial moral reasoning. The correlations appeared to hold for the youngest children (1<sup>st</sup> grade) but not for the older children (3<sup>rd</sup> and 5<sup>th</sup> graders).

Within the overall sample, authoritative, less restrictive and supportive child rearing practices were positively correlated with both reasoning and behavior, according to both teachers and classmates. Relationships between child rearing and prosocial behavior and reasoning held for both mothers and fathers. The study used correlation to examine the concurrent relationships between child rearing and prosocial development. As with all correlational studies, one must be careful not to draw conclusions about causality. This study appears to suggest that parents’ child-rearing styles impact their children’s prosocial reasoning and behavior, adding to the body of literature which highlights the important role parents play within families and within their children’s development.

A similar study conducted by Royal and Baker (2005) examined the effects of a Deliberate Psychological Education program on parents of school-aged children. The researchers’ aim was to indirectly influence the moral development of the children in this study by directly influencing the participant parents. A quasi-experimental, non-equivalent control group design was implemented with 18 parents in the treatment group

and 19 parents in the control group. All parents included in the study had at least one child enrolled in elementary school in a community in North Carolina. Participants' ages ranged from 27-50. One parent in the treatment group was excluded from the final data analysis as that respondent's data were deemed untrustworthy. In the treatment group, thirteen parents were women and five were men. All but one participant who was court ordered to attend the treatment group self-selected to be part of the parent education group. Nineteen participants were recruited from a local elementary school to be included in the no-treatment control condition. Thirteen of these participants were women and six were men.

Participants' moral judgment was assessed using the DIT (short form) (Rest, 1979). Perspective taking ability was measured using the Multiple Perspectives Inventory (Gorenflo & Crano, 1998), a self-report measure designed to measure the extent to which respondents consider multiple-perspectives in their decision-making process. The MPI consists of 20 items with Likert-style responses. An alpha reliability coefficient of .90 has been established for this measure. Problem solving ability was measured using the Parental Problem Solving Measure (PPSM) (Hansen, 1989). The PPSM was originally developed to compare the problem-solving abilities of mal-treating versus non-maltreating families. Three scores are generated with the PPSM, the number of solutions generated (a series of vignettes is read to each participant), the mean effectiveness of those solutions and the effectiveness of the best solution.

This study included two moral education groups for parents, one in the evening and one in the morning. The treatment condition focused on facilitating development rather than fostering specific child-rearing skills. A 16-item checklist of both implicit and

explicit objectives of the treatment group was created to ensure treatment integrity and was provided to an external observer who attended each of the group's sessions. Control group participants were given the pre and post test measures, but did not attend any education groups.

The primary threats to this study's validity included the non-random selection of participants, and a possible interaction of selection and maturation as well as an interaction between selection and history. The program's duration was also limited to four weeks; a very short time for a developmental intervention. No differences were found between the treatment and the control conditions of the DIT, the MPI and the PPSM-Number of Generated Solutions and PPSM-Effectiveness of Best Solution. The treatment and control conditions did differ significantly on the PPSM- Mean Effectiveness of Generated Solutions. This comparison of the treatment and control groups adequately addresses threats to this study's internal validity.

Significant post-test differences were found between the treatment and control groups on the DIT;  $F(1,35) = 16.56, p = .003$ , the MPI;  $F(1,35) = 3.98, p = .05$ , and the PPSM- Mean Effectiveness of Generated Solutions;  $F(1,35) = 8.80, p = .005$ . A large effect size was found for the primary dependent variable of moral judgment as measured by the DIT, and medium and small effect sizes were indicated for the MPI and PPSM respectively.

Post-hoc analyses indicated that there were significant relationships between moral development and number of generated solutions, moral development and effectiveness of the best solution, moral development and perspective-taking ability, number of generated solutions and the effectiveness of the best solution, number of generated solutions and



perspective-taking ability and mean effectiveness of generated solutions and effectiveness of best solution. These relationships between the dependent variables suggest that parents with higher levels of moral development generate more solutions to problems, the solutions they choose seem more effective and they may be better equipped to take on the perspective of others (Royal & Baker, 2005, p. 225). This study provides support for the potential for DPE programs to enhance the moral reasoning and perspective taking ability of parents and caregivers of school-aged children. Most importantly, this study offers further empirical support for the link between moral reasoning and the ability to take on multiple perspectives.

#### *Overview of Moral Development Literature*

This review of the literature on moral development and families highlights the relationships between familial and parental influence on moral development. Higher levels of moral development have been shown to increase social cooperation and understanding of self in relation to others (Rest et al., 1999). The literature implies that “learning to place one’s self in another’s shoes at both an intellectual and affective level generated moral development regardless of age” (Sprinthall, 1994, p. 95). These studies underscore the important role parents play within families. Moral development and other positive behavioral outcomes in children were significantly related to effective parenting styles and skills in all of the above studies. Various parenting skills and attitudes appear to be related to parents’ levels of moral development. The relationship between parents’ ability to take on multiple perspectives and moral reasoning was demonstrated (Royal & Baker, 2005). While the studies provide a broad overview of research done on moral development in a familial context, none of the studies reviewed explicitly considered

clinical samples of families seeking counseling services. Most of the studies reviewed were correlational studies that relied heavily on self-report measures. The link between moral development and various child and family outcomes is emphasized in this review of the literature; however, further research is needed to clarify the complex relationships that exist within the developmental context of family life. Despite a strong link between development and family outcome, this researcher was unable to find any studies that deliberately linked moral development and therapeutic intervention for families.

### *Ego Development*

The theory of ego development was developed by Loevinger (1976) and exists along a continuum that spans impulsivity, manipulation, conformity, autonomy and interdependence. The development of ego refers to “evolving meaning structures and to better adaptations between the person and the world” (Noam, 1998, p. 271). Loevinger conceptualized ego development as the process of an individual’s “striving to master, to integrate, to make sense of experience” (Loevinger, 1976 in Snarey, 1998, p. 164). As the ego develops it integrates various components of personality including moral judgment, cognitive complexity and ways of perceiving self and others into a structural whole that is “inseparable for analysis by individual domain or function” (Snarey, 1998, p. 164). This notion of the wholeness of ego development demonstrates that the new must be integrated with the old. One of the key roles of ego development is to clarify and synthesize one’s way of making meaning in the world (Hauser, Gerber & Allen, 1998). This synthesis represents a transformation of consciousness in which the individual takes on a more active role and puts one’s experience “within the scope of the ego as an

integrating agent... In active repetition the old is mastered, not eliminated or abolished but dissolved and reconstructed” (Hauser et al., 1998, p. 208).

Each stage of ego development builds upon the previous stage, creating a tapestry of increasingly complex and integrated perspectives (see Table 2.3). While ego and moral development are separate domains within a cognitive developmental framework, there are strong parallels between the two. Loevinger considered moral development as one of four components of ego development, and while Kohlberg did not explicitly agree with her assumption, “both lean toward support of an “ego subsumes moral” position” (Lee & Snarey, 1988, p. 154). The ego/moral primacy debate has not been resolved, but this researcher feels that the two domains are distinct enough in their foci to include them both as components in this study.

Table 2.3

Some Characteristics of Stages of Ego Development

<i>Level</i>	<i>Code</i>	<i>Control</i>	<i>Mode</i>	<i>Conscious</i>
<u>Preoccupation</u>				
Impulsive	E2 (I-2)	Impulsive	Egocentric, dependent	Bodily feelings
Self-Protective	E3 (Delta)	Opportunistic	Manipulative, wary	“Trouble,” control
Conformist	E4 (I-3)	Respect for rules	Cooperative, loyal	Appearances, behavior
Self-Aware	E5 (I-3/4)	Exceptions allowable	Helpful, self-aware	Feelings, problems, adjustment
Conscientious	E6 (I-4)	Self-evaluated standards, self-critical	Intense, responsible	Motives, traits, achievements
Individualistic	E7 (I-4/5)	Tolerant	Mutual	Individuality, development, roles
Autonomous	E8 (I-5)	Coping with conflict	Interdependent	Self-fulfillment, psychological causation
Integrated	E9 (I-6)		Cherishing individuality	Identity

*Note:* The code for the previous version used I-levels and Delta; the current code uses E-levels. Adapted from Loevinger (1976, 1987) [as cited by Loevinger, 1998, p. 5].

As with cognitive development in general, “ego development can occur throughout the lifespan and facilitates important shifts of perspective on the self and significant others in the social world” (Noam, Hauser, Santostefano, Garrison, Jacobson, Powers & Mead, 1984, p. 193).. The relevance of ego development for family counseling is supported by Krumpe’s statement that, “of all the developmental theories, this one seems most applicable to counseling and particularly to marital counseling” (2002, p. 2). Higher levels of ego development are associated with greater levels of nurturance, trust, interpersonal sensitivity, valuing of individuality, psychological mindedness, responsibility and inner control (Hauser et al., 1998, p. 207). The increased ability to nurture seems particularly relevant in justifying the use of ego development within a family counseling framework.

Ego development not only provides a relevant framework for family therapy, it also suggests the potential for change and “flexible adaptation in the face of normative stressors” (Hauser et. al, 1998, p. 215). Families who are referred for counseling often come during times of crisis, seeking new ways to make meaning of their struggles. Ego development offers a framework that allows us to understand how individuals experience themselves and the world. King, Scollon and Ramsey stated, “as we mature, we come to experience ourselves and the world in more complex ways;” this process of maturation may be useful to families as they encounter and attempt to adapt to new challenges (2000, p. 512).

#### *Ego Development and Families*

King, Scollon, Ramsey and Williams (2000) conducted a study with 87 parents of children with Down Syndrome (DS) where participants were asked to write narratives

about finding out that their child has DS. The initial sample consisted of 63 women and 24 men ranging in age from 26-67. The sample was 94% White/non-Hispanic, and 1% each, African-American, Hispanic, Asian and other. Eighty-nine percent of the participants were married, 9% were divorced and 1% were widowed. The average age of the child with DS was 6.7 years. Parents were assessed in a follow-up 2 years later. Of the 87 participants who originally participated, 42 participants completed the follow-up two years later. The researchers used The Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen & Griffi, 1985), the Sense of Coherence Scale (SOC; Antonovsky, 1993), the Life Orientation Test (LOT; Scheier & Carver, 1985) and the Rosenberg Self-Esteem Scale (Rosenberg, 1979) to measure the overall construct of subjective well being. Participants completed the Stress Related Growth Scale (SRGS; Park et al., 1996) to measure their stress related growth. The 18-item version of the Sentence Completion Test (SCT; Loevinger & Wessler, 1970; Hy & Loevinger, 1996) was used to measure ego development.

In addition to quantitative measures the researchers also looked at narrative accounts prompted by the statement, “Please write about the moment when you first were told that your child had DS. Write it like a story in the space below...” These narrative accounts were analyzed using content analysis. Distinctions between assimilation and accommodation were made in the coding process with assimilation defined as incorporating new experiences into one’s existing structures, and accommodation defined as a revision in structures or an essential change in response to the environment.

Results of this study indicated that having a coherent story was related to higher levels of subjective well being, while ego development was related to the process of

accommodation. Actively experiencing a “paradigmatic shift (evidence of accommodative change) was related to stress- related growth and ego development at both time periods” (King et al., 2000, p. 530). Results also suggested that accommodation was negatively related to subjective well being at the second measurement, implying that personal growth requires a sacrifice of happiness. These findings are supported by previous research suggesting that some negative feelings may be necessary for personal growth (Loevinger, 1976).

This study was correlational in nature and the results must not be interpreted causally. The researchers purposefully studied a group of individuals sharing a similar life circumstance (parenting a child with DS), allowing the researchers to focus on the process of change within the population rather than on the content of that change. This study is limited by its sample demographic; over 90% of participants were from intact marriages, which is not representative of the general population of parents of children with disabilities. The sample was also highly educated, which further limits the study’s generalizability. This research supports the relationship between ego development and the process of accommodation in the face of family stressors.

Florenzano, Ben-Dov, Ortega and Valdes (2003) conducted a series of studies on ego development that found a significant correlation between higher levels of ego development and better treatment outcomes in therapy. The first study examined 47 adolescents and the second replication study examined 77 adolescents who were receiving services at a University based counseling clinic in Chile. The initial sample included 19 women and 28 men attending therapy during 2001. The second study included 35 women and 42 men attending therapy during 2002 and 2003. These

individuals were given a self-administered outcome questionnaire (Lambert & Finch, 1999) at the onset of therapy and at the end of therapy. In addition each participant completed the Chilean version of Loevinger's Washington University Sentence Completion Test (WUSCT) and the Perception of Family Functioning questionnaire (CTF-CSF, Valdes et al., 1999). The CTF-CSF is a screening tool used to detect risk and protective factors in family functioning.

Individuals were randomly assigned to one of two treatment groups, either a psychoanalytically oriented therapy or to another modality that was not specified in the study. The two treatment groups were followed for six months. The researchers documented how each participant adhered to therapy by the number of sessions attended and the regularity of attendance. No significant differences were found between the two treatment groups; however, there was a significant correlation between ego development level and symptomatic change. There were no significant findings related to the Perception of Family Functioning instrument suggesting that family factors were not significant on therapy outcome for either sample. Results for this initial study indicated that for adolescents who were at lower ego developmental levels, therapy had less impact. These study looked specifically at adolescents receiving therapy in Chile and the sample sizes were relatively small. The lack of manualized treatment modalities for both treatment and comparison groups in both studies further confounds the results.

Noam et al., (1984) conducted a study that explored the relationship between ego development and psychopathology in a group of hospitalized adolescents. The sample included 114 adolescents (57 boys and 57 girls) aged 12-16 residing at an inpatient center of a major psychiatric teaching hospital in the Northeast (1984). Loevinger's Sentence

Completion Test was administered to measure ego development. The researchers administered Achenback and Edelbrock's Child Behavior Checklist to the mothers of the participants to measure psychiatric symptoms in this sample. Child Behavior Checklist factor scores were compared to ego stage using correlation and multiple regression analyses. The researchers wanted to look specifically at any patterns of behavior that were associated significantly with levels of ego development. Only 21.2 % of the sample had reached conformist (or higher) stages of ego development, indicating that this group lags behind compared to samples of non-clinical adolescents. The findings of this study indicated that psychiatrically relevant behaviors were related to ego stage. Specifically, Achenback and Edelbrock's externalizing factor had a strong relationship with lower levels of ego development. The authors suggest further studies to clarify the relationship between internalizing behaviors and higher stages of ego development, a finding the researchers were expecting but were unable to support with any significance. This study implies that ego development is a useful framework for understanding psychopathology, particularly with children and adolescents.

The literature suggests that family interactions can powerfully influence adolescent ego development. In a 1984 study done by Hauser, Powers, Noam and Jacobson, a coding system was developed to identify family interactions associated with variations in adolescent ego development. This coding system, called the Constraining and Enabling Coding System (CECS) examined patterns of interaction including affective and cognitive enabling and constraining. The study's sample included 61 adolescents and their parents who were given Loevinger's Sentence Completion Test and participated in a revealed-differences task, which used responses to Kohlbergian Moral



Dilemmas as prompts for discussion. Families were analyzed based on transcripts of these discussions using the CECS coding system and findings indicated that ego development scores contributed to explained variance in family interactions. The sample included individuals drawn from a psychiatrically hospitalized group (27) and a group of non-clinical high school students (34). Only students from two-parent families were recruited. The two samples were matched for age, gender and social class.

The psychiatric adolescents had significantly lower ego scores than the non-clinical adolescents. The findings of this study suggest that family interactions that emphasize warmth, acceptance and understanding support higher levels of ego development, while the absence of these types of interactions are related to decreased levels of adolescent ego development (Hauser, Powers, Noam & Jacobson, 1984). These findings are important as “the capacity to disentangle family behaviors tied to individual development from interactions that support or detract from certain types of meaningful family engagements offers the possibility of identifying varying familial environments associated with forms of developmental pathology and maturation” (Hauser et al., 1984, p. 208). This study offers significant support for the role of family in promoting child and adolescent ego development. The coding system developed for this study had only just begun to show properties of validity, so the results of this study must be considered in light of this limitation. This study also compares clinical with non-clinical samples, which may confound family and family- ego score relationships. The researchers did statistically control for psychiatric status, and predicted that if family differences were present in the overall sample they would be linked with the developmental variable. More research is needed to explore these variables in separate clinical and non-clinical samples.

### *Overview of Ego Development Literature*

These studies seem to suggest that ego development can be protective. “Having a more evolved understanding of what motivates people and the contradictory nature of human thought, feeling and action is generally more adaptive. It produces a greater repertoire of conflict resolution and protects the person from harm” (Noam, 1998, p. 272). While development provides protective factors to parents and their families including the potential to create more insight and a more tolerant perspective of others, one must remember that for ego development to occur there must be sufficient exposure to experiences that are disequilibrating, personally salient, emotionally engaging and interpersonal. (Noam, 1998; Manners, Durkin & Nesdale, 2004). Disequilibrating experiences alone are not sufficient. This researcher was unable to locate studies that examined interventions designed to increase levels of ego development in the context of family therapy.

The studies reviewed in this section highlight the relationship between ego development and a variety of clinical symptoms. Unlike the moral development studies reviewed in the previous section, nearly all of the studies this researcher found on ego development were focused on clinical populations. While the body of research exploring ego development looks specifically at clinical populations, few studies have been conducted examining the role of ego development in the context of clinical family samples. Of the studies presented above many were correlational. This researcher was unable to find studies that included ego development as part of a therapeutic intervention for families or individuals. Clearly, further research is needed to explore the potential of

ego development as an important component of therapeutic intervention for clinical populations.

### *Conclusions and Implications*

#### *Overview of the Research and Conclusions*

Family therapy attends to the unique challenges that families face in today's increasingly complex world. Families come to counseling looking for new ways to make meaning of their struggles. Counseling, with its emphasis on wellness and collaboration, offers these families alternative strategies for coping with the demands of their daily lives. Family counseling is uniquely relational, offering an interpersonal environment in which members begin to create new meaning together in the face of diverse family challenges. Postmodern approaches to family counseling have attended to these struggles by expanding upon traditional models, emphasizing respect, collaboration and diversity.

While postmodern approaches to family counseling provide strong scaffolding for working with families, their focus is not explicitly developmental. The literature reviewed supports future research that would attempt to integrate the promotion of greater moral and ego development within the context of family therapy practice. The research literature suggests that the domains of moral and ego development are particularly salient to our work with families and that the exploration of perspective taking is relevant within each of these domains. If the ability to empathize increases with "developmental progression from an egocentric to an allocentric (other-centered) orientation," then it seems that development is not only relevant but necessary in the field of counseling and counselor education (Carlozzi et. al, 1983, p. 113). The studies reviewed support the potential for future research that seeks to incorporate development

as an aim for work with families. These studies seem to imply that development “ought” to be the aim of our work with families and that this development must be deliberately promoted.

Very little research has been done on the developmental implications of family therapy. No studies were found in which specific developmental interventions were implemented during the course of family therapy. Such a study would have far reaching implications for both developmental theory and clinical family therapy practice. Chapter one introduced the topic of study for this research project. This chapter provides a review of the current literature related to moral and ego development in the context of family life. In addition, it provides justification for this study through the implications of the research presented. Chapter three will provide an overview of the research design and methodology utilized in this study.

### *Chapter Three*

#### *Research Methodology*

This chapter describes the research design and methodology of this study, including sampling and data gathering procedures, instrumentation, specific research hypotheses, data analyses, and a brief description of the intervention. Ethical considerations and limitations of this study are also presented.

#### *Population and Sample*

##### *Client Target Population and Sample*

The target population for this study was all families of children exhibiting disruptive behaviors who have been referred for family counseling by school professionals. This target population was chosen as it corresponds with current research literature on what typical families referred to counseling look like. While families referred through the schools represent a wide range of presenting issues from externalizing to internalizing behaviors, they share a common thread: children as symptom bearers. Robins and Rutter (1990) found that disruptive behavioral problems in children are the most frequent reason for referral to all forms of family therapy treatment, making up 95 percent of family referrals in community agencies. The sample for the current study was drawn from the accessible population of families referred for services through New Horizons Family Counseling Center at The College of William and Mary in Williamsburg, Virginia.

Randomly sampling all families, even in a relatively small geographical location is impossible. For this reason, a convenience sample was employed with the recognition that the results of this study are not be generalizable to all families. The sample is, however, carefully described in chapter five and inferences can be made as to what type of population this sample might be generalizable to. Thirty-nine families were initially recruited to account for experimental mortality. Twenty families were randomly assigned to the treatment group, and 19 were assigned to the comparison group. Attrition was expected in both treatment and comparison groups and the final sample was comprised of eleven families in the treatment group and eleven families in the comparison group. Both single and two-parent families were recruited, and both parents were assessed throughout the study. Parents completed two individual assessments, the Washington University Sentence Completion Test (WUSCT) and the Defining Issues Test II (DIT-II). Each family's relational functioning was also assessed through the counselor's use of the Global Assessment of Relational Functioning (GARF); a single score was given to each family rather than each individual parent due to the dependent nature of the condition of "family." Families recruited for the study were asked to commit to ten sessions of family therapy starting in the Fall of 2008.

#### *Counselor Credentials*

The current study used both Master's and Doctoral level counselors in implementing both the intervention and the comparison group counseling services. The ten counselors who participated in this study had a range of experience in family counseling from approximately 6 months to more than five years. The clinical team implementing counseling services in this study included four Master's level counselors and six Doctoral-level counselors. Three of the counselors were male and seven were

females. Both Master's and Doctoral level counselors were involved in both the treatment and control groups of this study. Counselors were asked to see families in both the treatment and control groups as research indicates that counselor effects often make a bigger difference on outcome than variation in method or services (Wampold, 2001). Researchers go to great effort to minimize the effect of the individual counselor or therapist when studying specific interventions; however, counselor effects continue to explain more of the variance in outcome within methods than the variance in outcome between methods (Rønnestad & Skovholt, 2003). Individual counselor effects were not statistically explored in this study as no one counselor had a large enough clientele to skew the data. Future research might look more closely at counselor effects and attempt to control for them by using fewer counselors and examining each counselors' impact on treatment.

Research literature on counselor efficacy supports the idea that expertise is not necessarily dependent on a therapist's years of experience in the field (Jennings, Goh, Skovhold, Hanson & Banerjee-Stevens, 2003). While it may appear logical that counselors with greater experience would have more expertise, the two constructs are not synonymous. Studies on long-term outcomes in therapy indicate that experience alone is not an adequate indicator of positive therapeutic outcomes or counselor expertise (Teyber & McClure, 2000). Lichtenberg (1997) completed a literature review in which he found evidence to support the claim that less experienced counselors do not appear to form inferior clinical judgments when compared to more experienced counselors. The ability of the counselor to form a therapeutic relationship has been shown to be more important for successful therapeutic outcomes than the years of experience of the counselor (Wampold, 2001). While the counselors' experience in the field was varied, each counselor had specific training on how to build and maintain a working therapeutic relationship with their clients. In addition, the counselors in this study participated in weekly group and individual supervision of their counseling activities by experienced

clinical faculty members who monitored the services provided to each family in this study.

### *Data Collection*

#### *Method*

Families participating in the study were randomly assigned to either the treatment or comparison group. The Defining Issues Test (DIT-2) and the Washington University Sentence Completion Test (WUSCT) were administered to all families. At the close of each family therapy session counselors assessed the families using the Global Assessment of Relational Functioning (GARF). Parents were also asked to complete a demographic questionnaire as part of the traditional intake process in family counseling. All counselors involved in the study were trained to administer each instrument. All sessions were video recorded to ensure consistent administration of instruments and treatment services. Parents in each family were pre-tested during the first session once consent to participate in the study was obtained. Parents were tested again during the tenth session or during their final session of counseling, whichever came first.

Counselors responsible for providing services and administering the DIT-2, WUSCT and GARF were trained prior to their first family session and again every three months during the implementation of this intervention to refresh their knowledge of the assessments prior to post-testing. All participants were informed of the purpose of the study. Participants retained the right to refuse to complete any instrument. Families were assessed during their regularly scheduled appointments to minimize missing data. Families who missed assessment sessions were asked to reschedule those sessions and complete the assessments. All responses and data were maintained in a confidential manner. Participants were given a code by which their data was identified to ensure



anonymity. A key with individual families' case numbers and identifying information was kept in a locked file cabinet for the duration of the study. Families who discontinued services prior to the tenth session were asked to schedule a follow-up interview during which they were post-tested with all instruments. Families who failed to schedule a follow-up interview and complete post-testing were considered non-respondents in the collection of data related to all hypotheses. Attrition/experimental mortality has been the greatest threat to internal validity in testing all hypotheses presented in this study.

### *Instrumentation*

Four instruments were used to collect data for the purpose of this study. Specifically, these instruments included: 1) informed consent form (see Appendix A), 2) Global Assessment of Relational Functioning 3) Defining Issues Test-2, and 4) Washington University Sentence Completion Test. Demographic information was collected using the client demographic questionnaires included in the initial paperwork filled out by all clients at New Horizons Family Counseling Center.

### *Informed Consent Form (Appendix A)*

The informed consent form outlines the study's purpose, describes what will be expected of each participant and describes how results of the study will be used. All participants were informed of their right to refuse to participate in the study. Families were also informed of their right to withdraw from the study without penalty. Families presenting for therapy that did not wish to continue participating in the study were offered alternative options for treatment. The informed consent form assured families of confidentiality and informed them that sessions were to be videotaped to monitor the therapists' adherence to specific treatment protocols.

*Global Assessment of Relational Functioning (GARF)*

The Global Assessment of Relational Functioning (GARF) is a 100-point scale that assesses interpersonal functioning in families along three dimensions: problem solving, emotional climate and organization. Patterned after the Global Assessment of Functioning (GAF), the GARF is completed by clinicians and includes a series of anchor points that describe each dimension of functioning. These anchor points represent functioning ranging from poor to satisfactory. Each anchor point accounts for an interval of 20 points on the scale. Family functioning along the three dimensions overlaps and is therefore intended to be rated globally (Yingling, Miller, McDonald, & Galewaler, 1998). The overall level of functioning is assessed with a global score which represents all three dimensions by averaging the three scores on the scale.

While research on the GARF is limited, preliminary support has been shown for its construct validity and inter-rater reliability. Ross and Doherty (2001) completed a study that demonstrates strong evidence of the GARF's construct validity when used by community-based family therapists. Their analyses showed that families with lower initial GARF scores had more severe overall problems and that families reporting enhanced overall functioning according to a client change questionnaire also showed an increase in GARF scores (2001). A negative correlation between initial GARF scores and the total number of sessions completed by a family was established in a study conducted by Rosen, McCollum, Middleton, Locke and Bird (1997) and reiterated by Ross and Doherty's later study (2001). Research on the GARF has consistently found that increased initial GARF scores are related to fewer overall sessions in therapy whereas

lower GARF scores are related to an increased amount of total sessions in therapy (Rosen et al., 1997; Ross & Doherty, 2001).

Rosen et al. (1997) conducted a study that examined the GARF's reliability and found a moderate, but significant, level of inter-rater agreement between master's-level therapists and their supervisors ( $r = .54$ ,  $p < .001$ ). The GARF was designed for clinical use by untrained observers and requires very little instruction. In Rosen et al.'s study, raters were not given extensive training on how to use the GARF (1997). In a later study, raters with no clinical experience were able to attain inter-rater reliability with a criterion rater with reported levels between .81 and .94 (Ross & Doherty, 2001; Yingling et al., 1998). For the purpose of this study, counselors attended two training sessions on how to assess families using the GARF. These training sessions were held once at the beginning of each academic semester and were conducted by the primary researcher and a faculty member familiar with the use of the GARF as a clinical assessment tool. Given the GARF's construct validity and reported levels of inter-rater reliability this researcher feels that the GARF was an adequate assessment tool for measuring participants' levels of relational functioning for the purpose of this study.

### *Defining Issues Test-2*

The Defining Issues Test (DIT) is a paper and pencil measure designed by James Rest to measure levels of moral judgment. Based on Kohlberg's moral judgment interview, the DIT accesses testers' moral schemas by posing hypothetical dilemmas and subsequently asking each tester to make a decision about each dilemma. Rest et al. revised the DIT in 1999, and the DIT-2 emerged. The revised version of the DIT provides more clarity, brevity and stronger validity criteria (Rest et al., 1999). The DIT-2 consists

of five hypothetical moral dilemmas which testers are asked to make a forced decision about. Each dilemma is followed by twelve statements which testers rate in order of each statement's importance in making a decision about the dilemma. The statements are presented in Likert-format ranging from "no importance" to "great importance." Once testers have ranked each of the twelve statements they are asked to choose the four issues they feel are most important in coming to a decision about the dilemma presented.

The DIT-2 uses a multiple-choice format that facilitates the assessment of levels of moral reasoning by asking testers to identify those issues that best represent their understanding of each dilemma without requiring the lengthy verbal rationale necessitated in Kohlberg's moral judgment interview. The DIT-2 acts as a device for activating moral schemas and for assessing those schemas in terms of important judgments (Rest et al., 1999). With the DIT, comprehension sets an upper limit on moral judgment stage while preference sets a lower limit on the stages that are accepted. These moral judgment scores have been shown to "correlate with other developmental scales such as Perry and Loevinger and predict to desirable behavior" (1999, p. 18). The test includes a subscale identified as the M score that includes meaningless items that are offered as responses to each of the dilemmas. The consistency check provided by the M score controls for an excessive number of these meaningless responses. If a respondent ranks or rates too many of these meaningless items as important the participant's responses are considered invalid (Rest et al., 1999). The test takes approximately 35-40 minutes to complete.

The DIT-2 produces both a Principled Reasoning score (P score) and an N2 score. For the purpose of this study, post-conventional moral reasoning was measured using

both P and N2 scores to examine changes in moral stage functioning for parents in counseling in both the treatment and comparison group. The P score is often expressed as a percentage and ranges from 0 to 95 with lower scores indicated lower levels of moral reasoning. The N2 score differs from the P score as it offers a more nuanced assessment of moral reasoning. The N2 score was developed to assess the tester's ability to distinguish post-conventional and conventional decision-making strategies. Based upon the P score, the N2 score considers whether the tester is able to rank post-conventional choices as more important than conventional choices when rating items for each dilemma (Thoma, 2006). The items chosen by the tester as most important represent the tester's modal moral schema (2006). The N2 score is strongly correlated (ranging from .8 to .9) with the P score. Test-retest correlations average range from .71 to .82 for the P index (principled moral thinking) (Bebeau & Thoma, 2003). Internal consistency for the DIT-2 (Cronbach's alpha) averages in the high .70s (2003). Estimates of internal consistency are for both the P score and N2 score.

Normative data for the DIT-2 P score for individuals having completed grades 10-12 indicate  $M = 33.13$ ,  $SD = 17.04$ , and  $M = 32.19$ ,  $SD = 15.19$  for those who completed vocational or technical school. Normative data for the DIT-2 N2 score indicate  $M = 31.69$ ,  $SD = 17.18$  for individuals who completed grades 10-12, and  $M = 28.7$ ,  $SD = 17$  for those who completed vocational or technical school.

#### *Washington University Sentence Completion Test (WUSCT) (Appendix B)*

The Washington University Sentence Completion Test (WUSCT) was developed by Loevinger and Wessler (1970) as a semi-projective assessment consisting of 36 sentence stems designed to elicit a response that indicates the respondent's ego

development level. Some sample statements include “Raising a family...” and “A good mother...” (Loevinger, 1998). Participants are instructed to complete each stem.

Different stems have been developed for men, women and children. Both short (18 stems) and long (36 stems) forms of the WUSCT exist; the short form was used for this study. Scores are assigned to each response based on Loevinger’s stages of ego development. While there is some loss of reliability when using the shortened form of the WUSCT, using the shortened form does not impact the assessment’s validity (Foster & Sprinthall, 1992; Novy & Francis, 1992).

For the purpose of this study, the WUSCT was administered to each family during their first counseling session and again during their final or post-test session. Parents were asked to complete each stem to the best of their ability. The responses given by each participant indicate how that respondent reasons about his or her actions, motivations and personal relationships (Hy & Loevinger, 1996). The completed sentence stems were coded and scored by two independent raters trained using the most current training manual and in consultation with an expert rater (Hy & Loevinger, 1996). During the training process, inter-rater reliability was established and confirmed in the coding of actual study instruments. Items on the WUSCT were individually scored for ego stage and added together to create the continuous item sum score (ISS) as well as the total protocol rating (TPR) which indicates ego stage. The TPR is determined by applying ogive rules, which account for the total distribution of scores across all 18 items (Bursik & Martin, 2006).

Table 3.1.

*Scoring Protocols for the WUSCT*

Stage	Name	Item Sum	Automatic Ogive	Explanation of Ogive
E8	Autonomous	109-118	No more than 16 ratings at E7	2 or more E8 or higher
E7	Individualistic	101-108	No more than 15 ratings at E6	3 or more E7 or higher
E6	Conscientious	91-100	No more than 12 ratings at E5	6 or more E6 or higher
E5	Self-Aware	82-90	No more than 9 ratings at E4	9 or more E5 or higher
E4	Conformist	76-81	No more than 6 ratings at E3	9 or more E4 or higher
E3	Self-Protective	68-75	At least 3 ratings at E3	3 or more E3 or lower

*Adapted from Hy and Loevinger (1996)*

Individual item reliabilities on the WUSCT range from .47 to .93 and inter-rater reliability for self-trained raters has been reported to range between .86 and .90 (Loevinger & Wessler, 1970). This range is analogous to that of professionally trained raters whose inter-rater agreement fell between .89 and .92. During the training and subsequent scoring of actual instruments for this study, Rater 1 established inter-rater reliability with the expert rater with 91.9% agreement across the 18 stems and 90% agreement for the TPR using an established coding set. Rater 2 established inter-rater reliability with the expert coder with 90.8% agreement across the 18 stems and 90% agreement for the TPR. A 93.8% inter-rater reliability was established between Rater 1 and Rater 2 across the 18 item stems, with a 90% agreement for the TPR. This level of agreement is congruent with levels reported by Loevinger and Wessler (1970) for self-

trained raters, indicating that strong inter-rater reliability was achieved in the scoring of this study's WUSCT protocols.

High levels of inter-rater reliability, internal consistency, and test-retest reliability have been demonstrated for the WUSCT (King et al., 2000). Internal consistency of the instrument has been reported with an alpha coefficient of .91 for all 36 items (Loevinger & Wessler, 1970). Its construct and concurrent validity have been established by several studies that have examined ego development in relation to other developmental stage assessments including moral development as well as attitude and behavioral measures (Lee & Snarey, 1988; Loevinger, 1998; Manners & Durkin, 2001). Gilmore and Durkin (2001) recently reviewed the validity of the WUSCT and simultaneously evaluated the soundness of the theory on which the WUSCT is based and found strong support for both the instrument's external validity and the soundness of ego development theory.

While the WUSCT has received strong empirical support for both its validity and reliability, two potential areas of concern must be considered when using this instrument; socioeconomic status and verbal fluency (Gilmore & Durkin, 2001). Research on the WUSCT has indicated a significant positive correlation between the length of completed item responses and the scored ego level of response. In addition, a strong positive correlation was found between higher socioeconomic status and scored ego level (2001). While not all researchers agree that these relationships exist (John, Pals & Westenberg, 1998), for the purpose of this study, these factors were carefully considered. During the coding, scoring and analysis of the protocol responses, attention was paid to perceived verbal fluency. Income level was reported as part of the demographic data collected for this study and correlational analyses were computed to determine whether there was a relationship between income and scored ego level in this study. No significant



relationship was found between reported income level and scores on the WUSCT in this study. These results are discussed in chapter five. Although some concern exists over the relationships between ego development and certain demographic variables, there appears to be significant support for the use of the WUSCT as a valid measure of ego development (Foster & Sprinthall, 1992; John et al., 1998). The WUSCT (short-form) can be found in Appendix B.

### *Demographic Information*

Demographic information was collected using the standard New Horizons Family Counseling Center intake form. This demographic information is collected from all families receiving services at the Counseling Center regardless of their participation in the study. Additional demographic information including education level and age was collected through questions that were part of the DIT-2.

### *Research Design*

This study was designed as an experimental pretest, posttest, comparison group design. The purpose of this study was to integrate a cognitive-developmental approach with family therapy to promote the moral and ego development of a clinical sample of families in counseling. This study explored whether a deliberate psychological education intervention in the context of family therapy could be effective in promoting gains in moral reasoning and ego development. In addition, the study also examined whether differences in moral reasoning and ego development are related to families' relational functioning. It was anticipated that those at higher levels of moral and ego development would have higher levels of relational functioning and would exhibit a greater ability to adapt to normative family life cycle transitions. More cognitively complex parents might

be better equipped to facilitate family organization, communication and emotional responsiveness. Specifically, the purpose of the current study was to answer the following questions:

1. What is the effect of a DPE intervention on the moral reasoning and ego development of families in counseling?
2. Is there a relationship between parents' stage of moral development and their relational functioning?
3. Is there a relationship between parents' level of ego development and their relational functioning?
4. Is there a relationship between parents' levels of ego development and moral reasoning?

#### *Hypotheses*

1. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in moral development as measured by the Defining Issues Test (DIT-2) when compared with parents of families receiving SFT alone.
2. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in ego development as measured by the Washington University Sentence Completion Test (WUSCT) when compared with parents of families receiving SFT alone.
3. Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in relational functioning as measured by

the Global Assessment of Relational Functioning (GARF) when compared with parents of families receiving SFT alone.

### *Data Analysis*

Mean scores were obtained for the DIT-2, WUSCT and GARF. A summary of mean scores is presented in chapter five (see Table 5.23). Chi Square analyses were used to determine if attrition rates were differential based on demographic variables. A Chi Square test for independence was computed to determine if differential rates of attrition existed by group. Analysis of Variance (ANOVA) was used to compare pre-test means between the treatment and comparison groups to determine that the groups were statistically equivalent at pre-testing. Correlational analyses were used to examine relationships between the various assessment measures. A significance level of  $p < .05$  was used. Multivariate analysis of variance (MANOVA) was used to test the effect of the treatment variable (DPE Intervention) on the dependent measures (DIT-2, WUSCT and GARF). Correlational analyses were conducted to assess the relationships between moral and ego development, moral development and relational functioning and ego development and relational functioning.

Levels of statistical significance were difficult to obtain for variables at the family level (GARF) due to the relatively small total sample size and the small numbers within each group (treatment and comparison). In addition to the analysis of statistical significance, effect sizes were calculated for each of the hypotheses using calculations for Cohen's D as outlined in Thalheimer and Cook (2002). Effect sizes help to show practical significance, which is paramount in determining the magnitude of the impact of

this study's developmental intervention as compared to a family therapy approach that does not include a DPE component.

### *Description of Intervention*

The conditions that must exist for developmental growth to take place include: a significant role taking experience as a helper, guided reflection, a balance between experience and reflection, continuity and an environment that is both supportive and challenging (Foster & McAdams, 1998). The developmental intervention designed for this study addresses the five components outlined above whereas the comparison group only addresses some of these components. Structural Family Therapy provides families with a continuous, significant role taking experience; however, specific emphasis is not placed on guided reflection or the balance between that reflection and experience. Family therapy often provides an environment that is both supportive and challenging, but a developmentally appropriate balance is not always intentionally fostered.

Families receiving the developmental intervention attended 10 weekly sessions lasting approximately 50 minutes each at New Horizons Family Counseling Center beginning in the Fall of 2008. The length of treatment was designed to address continuity as best as possible as brief interventions have been shown to be less effective in promoting development. Research has shown that developmental interventions must be both consistent and continuous over a six to twelve month period (Evans & Foster, 1998). While ten sessions only accounts for a three-month long intervention, it was expected that most families would not complete their ten sessions in less than five months. Families in the comparison group received 10 sessions of Structural Family Therapy as outlined by the manualized approach to SFT used at New Horizons Family Counseling Center.

Counselors in both the treatment and comparison groups were trained in a series of workshops prior to their sessions with clients and attended follow-up sessions twice a month to address treatment fidelity. Sessions were videotaped and watched to ensure that treatment was carried out as intended. Every 4<sup>th</sup> session, dilemma discussions were included within the treatment (intervention group) therapy session. If crises arose and these dilemma discussions needed to be moved, the subsequent dilemma discussions were moved as well so that they would still occur every 4<sup>th</sup> session.

Both real-life and hypothetical dilemmas were used in the treatment group. Real-life dilemmas were chosen in addition to hypothetical dilemmas for their personal significance and ability to activate emotional engagement in families. “The use of real-life dilemmas arising from people’s own experience may provide increased relevance to everyday family interactions” (Walker & Hennig, 1999, p. 360). It has also been noted in the literature that, in order to promote stage growth, experiences must be not only cognitively disequilibrating but emotionally engaging and interpersonally and personally relevant (Krumpe, 2002). These dilemma discussions were designed to attend to the criteria of both the significant role taking experience and the balance between experience and reflection within a developmental intervention. The discussions acted as a way for the families to begin to learn to problem-solve and consider each other’s viewpoints more collaboratively. In discussing real-life dilemmas the families were pushed to reflect on their own experiences in a personally meaningful way.

Parents participating in the study were asked to write journal entries following each session to reflect on that week’s session as well as any changes they have noticed within their family or within themselves. A team of researchers in Minnesota found that,

“role taking without continuity of reflection would not promote psychological growth”, further highlighting the importance of continuous reflection. (Sprinthall, ch. 5, p. 88). This satisfies the requirement of careful and continuous reflection, and the balance between experience and reflection called for in the DPE model. While parents were actively engaged in therapy each week, it remained crucial that they reflect on these experiences in order to make meaning of them in more integrated ways. Without guided reflection, meaning making becomes more difficult and may be overlooked. The reflection component of this intervention was critical in order to comprehend the significance of the role taking experiences the family experienced during their time in counseling.

During each session families were encouraged to try new ways of interacting with each other through the use of techniques such as enactment, dilemma discussions and empathy exercises. The disequilibrating process of engaging in new ways served as the significant role taking experience for the families. The importance of the weekly session is underscored when one considers that, “active practice in problem solving related to an actual role-taking experience and augmented by interactive exchanges with others seems to speed up the natural process of psychological development with gains that are maintained and cumulative” (Evans & Foster, 2000, p. 45). While this is an important component of an intentional developmental intervention, it must be noted that these experiences were present in both the treatment and comparison groups. Counseling provides a significant role taking experience and balanced support and challenge from the counselor; however, a more deliberate focus on the latter was apparent in the treatment group and acted as one of the primary differences between the two groups.

The counselors provided structure and challenge based on the family's developmental needs as discussed through weekly supervision with faculty members. These faculty members were trained in the intervention and guided the counselors in providing the adequate balance between support and challenge, structure and flexibility inherent in this developmental intervention. Counselors participated in both the treatment and comparison groups. The counselors were split into two separate groups for their weekly group supervision. During the first semester of this intervention the two groups of counselors were kept separate; one group saw only control group families, and the other only treatment group families. After this first semester, all counselors participated in seeing families from both groups. Careful attention was paid to how counselors carried out the intervention with specific emphasis placed on the importance of treatment fidelity. Counselors videotaped all of their sessions with families, and two of these videotapes were randomly selected each week to be viewed by the principal researcher for adherence to treatment guidelines. This intervention is described in further detail in chapter four.

#### *Ethical Considerations*

This research study was submitted as a proposal to the institutional review board (IRB) at the College of William and Mary. All participants were informed of their right to refuse to participate in the study. Families were informed of their right to withdraw from the study at any time without penalty. Families presenting for therapy that did not wish to continue participation in the study were offered alternative options for treatment. Participants signed an informed consent that assured them of confidentiality and informed them that sessions would be videotaped to monitor the therapists' adherence to

specific treatment protocols. This study did not involve deception and therefore no dehoaxing or desensitization was necessary post-treatment.

Participants in this study were placed in two different treatment conditions and were therefore not treated equally. At the conclusion of treatment and data collection, based on data analysis that supported research hypotheses one and two, participants in group two were offered subsequent sessions of SFT with the addition of the developmental intervention component. All participants were offered free subsequent sessions once data collection was completed if they wished to receive additional services.

### *Informed Critique*

As with any research in the field of therapy, outcome is often difficult to measure. In this instance we are looking at outcome related to relational functioning and moral and ego development. One must consider the diversity of issues families present with when seeking family therapy. Comparing families is difficult as they each present with different struggles and varied family configurations. The sample selected for this study was a convenience sample, which may not be representative of all families seeking counseling. A potential bias exists against families that do not seek treatment when experiencing distress.

Treatment fidelity is critical when attempting to evaluate the efficacy of one treatment approach over another (Byrne, Carr & Clarke, 2004). Without careful attention to treatment fidelity, both external and internal validity are threatened. Treatment fidelity is an important consideration when studying any phenomenon. In the field of counseling, it is a particularly relevant issue as counseling practices are often difficult to replicate. In previous studies, specific interventions with families were not the main focus. This study



attempted to outline treatment with enough detail to promote adequate treatment fidelity. It remains, however, difficult to ensure that each counselor facilitated sessions in a consistent manner and treatment fidelity remains a liability. Without explicit description of the experimental treatment, it is impossible to know what other treatment approaches may have inadvertently been applied, thus resulting in the additional threat of multiple treatment interference. A detailed description of the intervention has been developed for the purpose of this study and a manualized approach was used for both groups participating in the study. Careful attention was also paid to the comparison group.

A possible risk for pre-test sensitization existed as the pre and post-test measures in this study were identical. These measures provide the most adequate and empirically supported assessments of the constructs being studied, and while not perfect, were deemed sufficient by this researcher for the purposes set forth in this study. Time constraints posed an additional limitation on this study, as ten sessions may not have been enough for significant developmental change to occur. This study was designed with practical relevance in mind, and thus, the time constraints imposed by managed care were considered in the total number of sessions proposed for this intervention. Ten sessions appeared to be the most reasonable compromise between the theoretically and empirically suggested 9-12 months of intervention and the reality of limited sessions within a managed care environment.

The limitations of this study are balanced by its strengths. Very little research has been done on the developmental implications of family therapy. No studies were found in which specific developmental interventions were implanted during the course of family therapy. This study has the potential to expand upon current literature. The implications

of significant positive results within this study are great. Future research might focus on the importance of the length of treatment, which has the potential to influence public policy related to managed care. This study found significant developmental gains across both groups (although gains were more pronounced for the treatment group), and future research should consider exploring how family counseling facilitates this development and whether gains are maintained longitudinally.

### *Conclusion*

Chapter one introduced the topic of exploration for this study, while chapter two provided a review of the literature supporting future research that would attempt to augment one model of family therapy in such a way as to promote greater moral and ego development while simultaneously focusing on the development of more adaptive relational functioning. This chapter described the research design and methodology that was used in this study. Sampling, data collection and methodology, instrumentation, research design, hypotheses, data analysis procedures and a description of the intervention were included. Ethical considerations and an informed critique outlining the major threats to internal and external validity were also presented.

Conducting this study proved to be an exciting process for this researcher, as it examined issues related to family therapy and change. My beliefs about change have been transformed through the study of cognitive developmental theory, and this study acted as further support in grounding my theoretical stance in research that I have designed and participated in. Implications for my own practice are great; the observations I made throughout this process have undoubtedly influenced my own work with families.

## *CHAPTER FOUR*

### *Intervention Design and Methodology*

This chapter describes the design of the developmental intervention included in this study. First, a detailed description of the intervention is provided along with the purpose of the intervention. Specific family therapy objectives are discussed and individual session guidelines are laid out. Finally, this chapter includes a description of this researcher's log, which details the process of implementing the intervention and any challenges related to the implementation of this study.

### *Description of the Intervention*

#### *The Intervention*

Second-year Master's level and Doctoral level counselors were trained in implementing a developmental intervention within the context of their clinical work with families at a University-based family counseling clinic in Williamsburg, Virginia. This intervention included 10 structured sessions that outlined specific topics for discussion within each family therapy session. In addition to specific topics to be discussed during each session, families were asked to participate in reflection exercises each week. These exercises were provided to the families at the end of each session and were designed to promote active reflection of the topics discussed during family therapy. Empathy exercises were included as a component of the structured session outlines provided to each counselors. The session outlines were created through consultation with clinical directors and faculty supervisors of the family counseling clinic where this intervention was carried out.

Counselors were informed that their sessions would be tape-recorded and randomly checked for adherence to the specific session guidelines. This researcher trained all counselors in carrying out the developmental intervention. Counselors attended two formal training sessions in which the specific protocols for the intervention were explained. Counselors were required to attend meetings twice a month to discuss any challenges related to the implementation of the intervention and received training on how to facilitate specific exercises during these meetings.

This researcher designed the intervention for this study using the DPE-model for promoting cognitive development. Counselors were given a brief overview of the DPE-model that acted as the foundation for the intervention, and the five components of the DPE approach were emphasized as critical parts of this intervention. This intervention took place over the course of two academic semesters beginning in September 2008 and ending in May 2009.

### *Purpose of the Intervention*

#### *Promoting Moral Reasoning and Ego Development in Family Counseling*

The DPE approach to promoting cognitive development acted as the scaffolding for this intervention's design. The five components of the DPE model provided the underlying structure of each session of the intervention, while allowing counselors the flexibility to incorporate their own therapeutic styles and tailor the approach to meet the specific needs of each family included in the intervention. The families participating in this study were referred for counseling for a variety of struggles. The intervention was designed to provide structure to the course of therapy with each family through the use of the five components of the DPE model. While specific session guidelines were provided

to each counselor, the intervention was also designed to be developmentally appropriate for the needs of each family. The welfare of the family therapy clients included in this study was of primary importance and every effort was made to meet the family's needs while still maintaining treatment integrity. Counselors were trained to respond to client crises and were instructed to return to the intervention once those crises had been addressed. For this reason, many families participating in the intervention attended more than ten sessions before they had completed the ten sessions laid out in the intervention.

Faculty supervisors acted as support systems for each counselor. Supervisors attended all of the counselors' trainings and were asked to focus on the 5 elements of the DPE model in their work with the counselors. Supervisors facilitated weekly group and individual supervision to the counselors and provided this researcher feedback on the day-to-day implementation of this intervention. All supervisors were trained in and familiar with the components of DPE and carefully monitored the therapeutic objectives and developmental needs of each family in the intervention.

The DPE model was developed by Mosher and Sprinthall (1971) as a way to enhance the learning experiences of students. This decidedly developmental approach to learning was based on the work of Kohlberg, who called for the presence of significant role-taking experiences in intervention strategies designed to enhance learning (Kaiser & Ancellotti, 1993). The DPE-approach to development contends that psychological growth is not automatic and must be deliberately stimulated within an adequate learning environment (Morgan, et. al, 2000). Within these "adequate" learning environments there exist certain conditions that must be met for developmental growth to take place. These conditions comprise the five components of the DPE-model and include: a significant

role taking experience, guided reflection, a balance between experience and reflection, continuity and an environment that is both supportive and challenging (Foster & McAdams, 1998).

### *Intervention Objectives*

The principal objective of this intervention was to promote moral reasoning and ego development in families. Coming from the theoretical standpoint of systems approaches to work with families, this researcher focused on the promotion of development within families through specific focus on enhancing the development of parents. Historically, the role of parents in promoting the development of their children has been largely overlooked, however, recent studies demonstrate that parents are important sources of influence on children's moral development (Walker & Hennig, 1999; Royal & Baker, 2005). While parents are the initial source of moral behavior and modeling for their children, many parents "lack the higher levels of reasoning and prosocial development needed to enhance the moral development of their children, yet they remain important sources of social modeling" (Royal & Baker, 2005, p. 216). The need for this intervention was clear, "while there may be character education and moral development programs for children and adolescents, little or nothing is available for parents" (Royal & Baker, 2005, p. 217).

The purpose of this intervention was to facilitate development in families by working intentionally with parents in the context of family therapy. Specific objectives were presented to the counselors implementing the intervention and included the following:

- To facilitate discussions of justice and fairness in the context of family therapy.

- To facilitate exploration of how families handle decision-making, particularly around issues concerning morality.
- To discuss family organization, including rules, roles, boundaries and family hierarchy.
- To promote moral reasoning through the use of age-appropriate dilemma discussion exercises.
- Families will engage in one structured empathy exercise designed to increase perspective taking and emotional nurturance- additional empathy-related discussions are included throughout the intervention.
- To encourage parents to develop perspective on their therapeutic experiences through the use of guided reflection.
- Providing continuous support for parents as they explore alternative ways of interacting with their children/each other.
- Providing developmentally appropriate challenge to encourage families to evaluate their interactions, behaviors and family structure.

### *Requirements*

Counselors were required to attend staff meetings twice a month. These meetings served as an open forum to discuss the challenges of implementing the intervention. In addition, two counselors per week were required to provide videotapes of their sessions to this researcher. These videotapes were reviewed using the intervention timeline protocol. Tapes that did not sufficiently address the specific objectives of each session's protocol were returned to the counselor with instructions to include the omitted objectives in their next session with the family. Counselors were expected to attend weekly

individual and group supervision sessions with faculty supervisors trained in the intervention protocol.

Families were asked to commit to ten, 50-minute family counseling sessions for the purpose of the intervention. Additional services were offered to families who felt they needed services beyond the 10 sessions included in the intervention. Parents were informed about the nature of the study and were given the option not to participate in the study. Those families who chose to participate in the study were given a journal and expected to reflect on their experiences in counseling between sessions. Specific reflection prompts were given to the parent or parents in each family at the end of each session. These reflection prompts reflected the objectives of each session and included a tie-in to the objectives of the subsequent week's session. Parents were expected to attend weekly sessions and come to each session prepared to discuss their reflections from the previous session. In addition, families were asked to complete any homework assignments given by their counselors which included activities related to the dilemma discussion and empathy exercises.

### *Intervention Design*

This intervention was designed to include specific emphasis on the five elements of the DPE-model: a significant role-taking experience, continuous guided reflection, an intentional balancing of action and reflection, an intentional balancing of support and challenge and continuity. These elements acted as the overarching structure of the intervention. The following section describes how each component of the intervention attends to one or more of these five objectives and provides a brief overview of each aspect of the intervention. Finally, a description of specific session objectives is included.



### *The Role-Taking Experience*

Both the intervention and comparison groups share one aspect included in the DPE-model: the significant role-taking experience. The DPE-model calls for a significant role-taking experience to enhance growth and development, and for the purpose of this intervention, family counseling satisfies this component. Counseling is a novel experience for most families. The act of family therapy brings families to share their struggles with someone outside of their immediate family system. By attending weekly sessions and exploring their family's struggles, participants were engaged in a significant role-taking experience. The role-taking experience in and of itself is not sufficient in promoting moral reasoning and ego development, but it does act as the foundation for both the intervention and comparison groups in this study. Family counseling becomes the environment in which development is facilitated within this intervention.

### *Journals/Reflection Exercises*

Journals were provided to each family during the first family counseling session. Parents were instructed to use the journals to reflect on their experiences within and between counseling sessions. Reflection exercises were given to parents at the end of each session. These reflection exercises were based on the content of the last session attended and sometimes included specific tasks for the families to complete together between sessions. Continuous, guided reflection is at the heart of this intervention. Beyond what happens in the 50-minute counseling session, families are asked to step back and reflect on their experiences as they explore new alternatives together. Journaling acts as the vehicle for reflection, and the physical journal was included in this intervention to give parents a tangible object to represent the often intangible act of

reflection. Research supports the importance of reflection in promoting psychological growth and demonstrates that role-taking experiences themselves are not sufficient in facilitating development (Sprinthall, 1994). Parents included in this intervention were asked to engage continuously in the process of change, transcending the limits of the 50-minute session.

Journaling and reflecting satisfy three components of the DPE-model simultaneously. Careful and continuous guided reflection is met through the intentional assignment of reflection exercises between sessions. Continuity is encouraged through the inclusion of specific intervention and session objectives included in each reflection exercise as well as through the act of reflecting and engaging between sessions. A balance between reflection and action is partially met through this component of the intervention as the reflection exercises provide the opportunity for parents to engage in this new experience in an introspective way. The reflection component of this intervention provides the most striking contrast between the intervention and comparison groups; it acts as the keystone of this intervention, providing families with an opportunity to step back from the role-taking experience of family therapy and begin to make sense of, and integrate these new alternatives.

The following prompts were included as reflection exercises:

Session One: What makes your family unique or special? (think about your family history as you reflect on what makes your family unique.

Session Two: What are your family's greatest strengths?

What are your family's greatest struggles?

Session Three: What have you taught your children about being a member of a family?

How have your experiences in your family of origin shaped your experiences as parents?

Homework for family: In preparation for the next session think about how the family handles tricky situations/dilemmas.

Session Four: Think about how your family responded to the dilemma activity in session. What was surprising?

Session Five: How do you make decisions for your family?

How do you communicate those decisions to your family members?

Session Six: What (and how) have you taught your children about right and wrong?

How did you learn to distinguish right from wrong?

Session Seven: How have you taught your children about fairness?

Where did you learn about issues of fairness?

Homework for family: In preparation for the next session think about a dilemma that the family has faced

Session Eight: Reflect on the dilemma discussion during this past session.

What have you learned about individual family members and about your family as a whole from the family dilemma discussions?

Session Nine: What did you learn about your family during the activity done in session?

What surprised you?

Session Ten: Reflect on your family's discussion of feelings: How did your family come to express feelings in this way?

How did you learn to communicate your emotions/feelings?

*Empathy Exercise*

One structured empathy exercise was included in the intervention to promote increased perspective taking among family members. This exercise adapted from Furman (2005) acted as a disequilibrating event for most families in the intervention as it asked individual family members to practice perspective taking with each other. This exercise asked families to remember, in as much detail as possible, a time that they felt deeply accepted and understood by someone. Family members were asked to think of what that person said or did to make them feel so accepted and cared for. In addition, members were asked to reflect on how they responded to this person and what they enjoyed most about this experience. The family was then asked to spend 10-15 minutes writing down their experiences. These experiences were then shared with each family member during the counseling session while the counselor worked to draw out common themes among family members' stories.

The act of practicing empathy served as a source of both challenge and support within the DPE-model. Family members were challenged to listen to each others' experiences while the counselor drew out common themes. Sharing these experiences proved to be challenging for many families in the intervention and effectively unbalanced the family system by asking family members to listen to each other in an emotionally connected way. The purpose of this exercise also included support: in hearing family members discuss times that they felt understood and cared for, each family member was given an opportunity to learn something about the needs of their family. Empathy and perspective taking were encouraged throughout both the intervention and the comparison groups as part of the process of counseling.

### *Dilemma Discussions*

The use of dilemma discussion exercises is standard in the field of moral education (Narvaez, 1994). This intervention seeks to promote moral reasoning and facilitate discussions of justice and fairness within the family system. Dilemma discussions provide both structure and content to this intervention by asking families to make a decision or reach a consensus on a salient interpersonal issue tied to larger moral themes. Two types of moral dilemma discussions were used with each family. In the first, counselors provided the family with an age-appropriate story in which characters were faced with a moral dilemma. The counselors facilitated discussion about the dilemma and asked the families what they would do in a similar situation. Parents were later asked to reflect on the dilemma discussion exercise and the process of moral decision making in their journals following the session. This dilemma exercise included the following stories and follow-up questions. Different stories were used based on the age of the youngest child in the family.

#### *Dilemmas for Session #4*

(HS: High School; ES: Elementary School; MS: Middle School)

#### **Darren (HS)**

Darren is a transfer student in his sophomore year in high school. By November, he had made some good friends through his soccer team and classes, but still felt on the outside of the more popular students. He has a great relationship with his mom, and trusts her advice to just give it time.

The first weekend of Thanksgiving break, rumors started that a blow out party was happening at a sophomore's house while the parents were out of town. Darren didn't

know the girl well but she was one of the most popular girls in the class and most of the upperclassmen were planning on attending, as well. One of the hottest junior girls had already asked him if he would be there. Everyone was saying this was going to be the best party of the year. This seemed like the perfect opportunity to break out of his small group of friends and hang out with the students everyone always talked about. There was no way his mom would let him go to this party if she knew the parents were out of town, and he wanted to go very badly. What would you do?

**Lea (MS/HS)**

Lea is a member of a local theater group in a nearby city. Lately there has been talk going around that some members have been exempt from auditions for the last few productions. Leah knew in the “real world” that can happen sometimes. Some productions have such huge numbers of applicants and so little time that the more experienced, well known actors and singers sometimes get bumped up into the cast without having to try out. But, this wasn’t Broadway, this was a local teen theater group and the whole idea was to give everyone a chance to prove him or herself. She and her friends talked about the rumor and how, if it was true, how unfair it was. It’s one thing to know someone probably deserves to be cast in the production, but another to just put that person in without letting others compete for the same role.

The first week of tryouts for the next musical production Lea was called into the director’s office. He told her she was in for one of the main singing parts. She was ecstatic at first. It was the role she had wanted more than any other. It was a starring spot and would set her up for amazing roles in the future. Then, she realized the director meant she didn’t have to audition. He explained that they simply didn’t have enough time

to see every performer's audition. They knew her work and knew she was right for the role.

Lea was conflicted. What would she say to her friends? How would she explain this to them? She decided she would raise the question to the head director before she left his office. She asked, "What do I tell the rest of the cast?" He replied, "They don't need to know. This is often done with the strongest performers. Just skip the audition and we'll take care of the rest." What would you do? Would you talk to your parents about this if you were in Lea's place? What do you think they would do? Would you agree?

### **Hannah (ES/MS)**

Hannah was caught cheating on her math quiz. She had been doing poorly in math and her parents had threatened that if she didn't raise her grades they wouldn't let her play on the softball team. So she cheated. When the teacher asked her about it, she denied it at first, but finally admitted to writing down the answers ahead of time.

A parent conference was called and Hannah had to sit with her parents, the teacher, and the principal to discuss the school policy on cheating and lying. On the way home, her father told Hannah he was deeply disappointed in her and expected more from her in the future. That night, she felt like the whole world was against her, but she also felt guilty for letting her parents down.

That weekend, Hannah and her family went to a movie. When they got to the ticket window Hannah's dad asked for children's tickets for both Hannah and her 16 year old brother. Hannah looked over at her brother, who stared down at the sidewalk and hunched his shoulders hoping the ticket seller wouldn't notice that he was above the age for a child's ticket. The ticket seller glanced suspiciously back and forth between the

father and the brother, and then, with a doubtful look on her face, she handed them the two child's tickets. How do you think Hannah felt in this situation? How is what Hannah's father did different from what Hannah did? Have you ever felt like doing the "wrong thing" because you felt like it was worth it? What would you do in this situation?

### **Sam (ES)**

Sam knew something was weird the second he got to class on Tuesday morning. He saw kids whispering and pointing at him. Some were looking at him funny. He sat down next to his best friend and picked up the graded report the teacher, Mr. Crosby, had graded over the weekend. Sam looked at the "A-" and forgot about the rest of the class for a minute. He had worked hard at that report and was thrilled it had paid off. He looked up and saw a bunch of kids staring at him. Sam whispered to Dylan, "What's going on?" Dylan, looked down and said quietly, "Conner told everyone you copied your report from the internet." "But, that's a lie!" Sam said. "I never cheat and everyone knows it." He was hurt and angry. He couldn't focus the rest of the morning in class.

At recess he went up to Conner and asked him if he had really told everyone he had cheated. "It's no big deal," Conner scoffed. "I only told a few people. Lighten up. It was just a joke." Sam turned and walked away. He wanted to yell at Conner, or hit him, or something. He just wanted to make Conner feel as bad as Conner had made him feel.

For the next two days, Sam avoided Conner but Sam and Dylan made up as many lies as they could think of about Conner to get back at him. They told kids that he was jealous of anyone who did well in school because he almost failed fourth grade last year. They told the girl Conner liked that he still wet his bed sometimes.



On Friday, Mr. Crosby had all three boys stay to talk with him during recess. He told them they had until the end of recess to work out whatever it was that was going on between them. If they had not all forgiven each other by the end of recess, they had to go to the principal's office. Then Mr. Crosby left the classroom.

The three boys stared angrily at each other waiting for someone to say something. Sam didn't know what to say. All he knew was that he was tired of being mad and hurt. What would you do?

In the second dilemma discussion exercise, counselors re-introduced their client families to the construct of the ethical dilemma and asked each family to come up with a similar type of dilemma that they had faced in their own lives. The family's task for that session was to discuss their dilemma and to decide what to do about it. Both real-life and hypothetical dilemmas were included in this intervention as real-life dilemma situations have added personal significance and increase the ability to engage families emotionally. The initial dilemma discussion exercise used a hypothetical dilemma to introduce the families to the idea of dilemmas and dilemma discussions. Real-life dilemmas meet the requirement of the significant role-taking experience as they arise from the family's organic experience and are relevant to everyday familial processes. These types of dilemmas also fulfill the need for a balance between action and reflection in the therapeutic process. The dilemmas themselves are re-enacted in the therapeutic session while family members reflect on how they have responded in the past and how they might respond differently in the future. Walker and Hennig (1999) advocate for the use of real-life dilemmas with families, as they provide "increased relevance" (p. 360) to the family's everyday experience.

Dilemma discussions offer families the opportunity to begin to practice problem-solving skills while also encouraging conversations about issues of justice and fairness.

### *Description of Specific Session Objectives*

#### *Intervention Timeline*

##### Session One

Initial Paperwork including all agency standard forms, informed consent, and demographic questionnaire is completed

Parents complete first round of measures (WUSCT, DIT-2)

Counselor completes initial GARF scores

Counselor has family contract for 10 sessions emphasizing the importance of regular attendance

Introductions and initial discussions about how counseling will work

- Reflection exercise: Journals will be an important part of this intervention and parents are informed about the role of journaling in family counseling. Parents begin the reflection process after this first session with an initial exercise designed to begin the process of reflecting on their family and their work in family counseling.
- Initial journal assignment asks parents to reflect on what makes their family unique (parents are asked to include family history in this reflection).
- Parents are informed that these journal assignments will be reviewed at the beginning of each session as a way to begin each session and that the reflective component is as important as the work done weekly during sessions. Parents are informed that the reflection exercises do not necessarily have to be written, as long as each parent

reflects on the topics presented during each session. If the parent(s) is unable to complete the reflection assignment between sessions, the reflection will be completed verbally at the beginning of the following session.

### Session Two

Counselor and parent(s) review the reflection assignment with family members

The counselor facilitates a discussion of what makes the family unique:

- Discussion of family's presenting problems- reason for referral, general family history
- What makes your family different from other families? How are you unique or special?

Second reflection exercise assigned for the following session

- Reflection exercise: Parent(s) are to reflect on their family's strengths and struggles

### Session Three

Counselor and parent(s) review the reflection assignment with family members

The counselor facilitates a discussion of the family's strengths and struggles based on the last week's reflection assignment.

- What does it mean to be a family? How is a family different from other relationships?
- Reflection exercise: What has the parent(s) taught children about being a member of a family. How have their experiences in their families of origin shaped their experiences as parents?

- Homework for family: In preparation for the next session think about how the family handles tricky situations/dilemmas in preparation for the first dilemma discussion.

#### Session Four

Counselor and parent(s) review the reflection assignment with family members

Dilemma Discussion Exercise #1:

- First Dilemma Discussion exercise: Counselor gives dilemma example and explains the exercise. The family reads about a dilemma that another family has encountered. Each family member is given an opportunity to think about how they would respond to the dilemma. The family must then make a decision together about what they would do if they were faced with this dilemma. The dilemmas included in this exercise are listed above and in Appendix C.
- The counselor facilitates a discussion about how the family came to make their decision about the dilemma.
- Reflection exercise: Parents are to reflect on how their family responded to the dilemma discussion exercise in session. What was surprising?

#### Session Five

Counselor and parent(s) review the reflection assignment with family members

Family engages in discussion about decision-making:

- Decision making exercise: Counselor facilitates discussion of how decisions are made within the family unit. Who makes decisions in the family? How do family members make decisions (individually, as a family etc.)?

- Reflection exercise: Parent(s) are asked to reflect on how they make decisions within the family and how they communicate their decisions to other family members

### Session Six

Counselor and parent(s) review the reflection assignment with family members

The counselor facilitates a discussion of issues of right and wrong:

- How does the family decide what is right and what is wrong? How does each family member know right from wrong?
- Reflection exercise: Parents reflect on how and what they have taught their children about right and wrong as well as how they learned to distinguish right from wrong.

### Session Seven

Counselor and parent(s) review the reflection assignment with family members

The counselor facilitates a discussion about issues of fairness:

- What is fairness? How does the family negotiate what is fair and what is unfair?
- Reflection exercise: Parents reflect on how they have taught their children about fairness; where did they (parents) learn about issues of fairness?
- Homework for family: In preparation for the next session the family is asked to think about a dilemma that they have faced (counselor gives a brief example)

### Session Eight

Counselor and parent(s) review the reflection and homework assignments with the family

The counselor engages the family in the second dilemma discussion exercise:

- Dilemma discussion exercise #2: Family members are asked to share the dilemma they thought of together as a homework assignment for today's session. The counselor instructs the family to think of a time that they encountered some sort of dilemma (a time when they did not know what to do) and asks the family to describe the dilemma in detail. Family members then discuss how the family came to decide what to do- what action to take about the dilemma.
- Asking members what they might have done differently if faced with this dilemma again extends this exercise. Individual family members are asked to reflect on how they might have handled this dilemma if they had the power to make a decision about it on their own.
- Reflection assignment: Parents reflect on the dilemma discussion experienced during the session. What have they learned about individual family members and about their family as a whole from the family dilemma discussions?

### Session Nine

Counselor and parent(s) review the reflection assignment with family members

The counselor facilitates an empathy exercise with all family members:

- Empathy Exercise: Families are asked to close their eyes and remember a time that they felt deeply accepted and understood by someone. They are to remember this time in as much detail as possible. What did the other person say or do to make them feel so accepted and cared for? How did they respond to this other person? What did they like about this experience?

- Family members will then spend 10-15 minutes writing down their experiences (or drawing about them if writing is not an option). These experiences will then be shared with the family during the session.
- The counselor engages the family by drawing out common themes among family members and paying careful attention to how family members respond to each other.
- Inform family that the next session will include the same assessments they took at the beginning of counseling.
- Reflection Assignment: What did you learn about your family during this exercise? What surprised you?

#### Session Ten

Counselor and parent(s) review the reflection assignment with family members

The counselor engages the family in a discussion about the empathy exercise and processes any feelings or thoughts that may have arisen between sessions.

Administer DIT-2 and WUSCT

- How do family members communicate feelings to each other?
- Reflection exercise: Parents reflect on family discussion of feelings and how the family expresses emotion. How did the family come to communicate feelings in this way?

After the completion of 10 sessions, family members are offered continued services if they feel they would like to continue in family counseling. Further opportunities for reflection are provided to all parents in the intervention group and a session outline was provided to counselors should a family choose to continue with the intervention. This

intervention was designed as a 16 session treatment plan that was later condensed to ten sessions due to high participant mortality.

### *Researcher's Log*

As training and implementation of this study began, this researcher kept a log to detail the challenges that arose in the various phases of the research process. This researcher's log included notes on the random treatment video checks that were conducted each week as well as notes collected during each training session held throughout the intervention. As the intervention began this researcher made note of a small degree of initial resistance on the part of some of the counselors in the intervention group. This resistance was particularly strong prior to the first training session. Counselors seemed to be hesitant about the intervention as many felt it would provide too much structure and not allow for individual counseling styles. As the first round of training was completed this researcher noted a significant drop in resistance to the intervention. Many of the counselors reported that they felt enthusiastic about the intervention and that it did not pose a threat to each counselor's individual counseling techniques and style. Counselors met weekly in supervision groups and discussed various aspects of the implementation of the intervention. These weekly supervision meetings provided a forum for feedback and support for the counselors implementing the intervention.

Prior to implementing the intervention, this researcher noticed that many counselors were concerned about how to make each intervention session's objectives and activities relevant to their individual client families. Counselors were assured that their clients' needs were of primary importance and that the objectives for each session were to



be tied into the family's presenting issues. Resistance to the intervention subsided significantly after discussions of how to make the intervention objectives meet the needs of the diverse families participating in this study. By the end of the first academic semester the counselors seemed more comfortable in carrying out the intervention and gave positive feedback about the various intervention exercises.

To attend to treatment fidelity, this researcher randomly collected videotapes from two counselors each week. Counselors were asked to provide the session number presented in the videotape. Tapes were watched and assessed for treatment fidelity using the intervention guidelines as a checklist. Two key components of the intervention were included in the assessment for treatment fidelity; adherence to the particular session's content and objectives, and a focus on the reflective component for that week's session. During the first six weeks of the intervention four tapes were returned to counselors with instructions to attend more carefully to specific session guidelines. These counselors were asked to cover the session objectives this researcher felt were missed in the initial tape and were asked to submit a tape of the session in which those objectives were covered. After the first six weeks of implementation all videos met the specific session guidelines set forth in the intervention time line.

Counselors in both the treatment and comparison groups were trained on how to assess families using the DIT-2, WUSCT and GARF. Training in using these assessments was provided twice a semester and was mandatory for all counselors. This researcher did not have difficulty in administering any of the instruments used for the purpose of this study. Counselors were provided with instructions on how to administer each assessment. Two separate training sessions were held in each of the supervision groups to train

counselors in administration of the GARF. This researcher collaborated with faculty in training the counselors to properly administer the GARF. All counselors participating in this study were expected to provide GARF scores for their families after each counseling session. Counselors in this study had received training on administering the GARF prior to this study, and all counselors were familiar with the instrument. For the purpose of this study, counselors provided GARF scores for the first and tenth sessions as pre and post-test data.

## *CHAPTER FIVE*

### *Results*

This chapter outlines all statistical analyses used for the purpose of determining the outcomes of this study. A detailed description of the sample and study design are included. Descriptive statistics for both the treatment and comparison groups are presented. Next, formal statistical analyses of each research hypothesis are discussed. Finally, this chapter presents the results of all statistical analyses conducted.

### *Description of the Study*

#### *Sampling, Test Administration and Scoring*

This study investigated the impact of a family counseling based DPE intervention on parents' moral reasoning, ego development and relational functioning. This study utilized a pre-test post-test experimental design through which a treatment group receiving the DPE intervention was compared with a comparison group receiving standardized family counseling services. Participants were pre-tested beginning in the fall semester of 2008 prior to receiving the DPE intervention or comparison group family counseling services. Participants were tested once more at the conclusion of ten sessions of the DPE intervention or standardized SFT services. Two instruments were administered to each parent participating in the study, the Defining Issues Test- 2 (DIT-2) and the Washington University Sentence Completion Test (WUSCT). In addition, counselors implementing both the treatment and comparison group counseling services assessed all families using the Global Assessment of Relational Functioning (GARF)

during each session. Pre and post-test scores from each instrument were collected for all parents and/or guardian adults in each family.

The treatment group participated in a ten-session DPE-based family therapy intervention previously outlined in chapter four. This intervention was implemented by the principal researcher and a group of nine master's and doctoral level counselors.

### *Demographic Information*

#### *Total Pre-Test Sample*

Demographic data were collected from each family during the client intake process as part of their standard clinical paperwork. Fifty-one parents ( $N = 51$ ) from 39 different families were included in the initial sample. These 51 parents completed the two pre-test measures (DIT-II and WUSCT) and were rated by their counselors using the GARF. Of the 51 parents included in the initial sample, 25 ( $n = 25$ ) parents from 19 families were assigned to the comparison group and 26 ( $n = 26$ ) parents from 20 families were assigned to the treatment group. Twenty-nine parents from 22 different families made up the final sample ( $N = 29$ ) for this study, representing 56.8% of the original total sample of parents. Parents were relatively equally distributed between the two groups at post-testing with 13 ( $n = 13$ ) parents remaining in the control group and 16 ( $n = 16$ ) parents remaining in the treatment group. Demographic information for each participant is presented in this chapter as well as for each family. Certain demographic variables were at the level of the family and were not included at the individual level, these variables included the family's configuration, income, number of sessions attended and time in counseling.

### *Gender*

The total pre-test sample included 37 females ( $n = 37$ ) representing 72.5% of the total sample and 14 males ( $n = 14$ ) representing the remaining 27.5% of the total pre-test sample. Nineteen participants, or 76% of the comparison group were female and 6 participants, or the remaining 24%, were male. The treatment group at pre-testing was comprised of 18 females and 8 males, 69.2% and 30.8% respectively.

### *Race*

The total pre-test sample included 35 participants who self-identified as Caucasian, 13 Black/African-American participants and 3 Multiracial/Other participants, making up 68.6%, 25.5% and 5.9% of the total sample at pre-test. The comparison group was comprised of 9 Black/African American participants (36%) and 16 Caucasian/White/European American participants (64%). The treatment group included 4 Black/African American participants (15.4%), 19 Caucasian/White/European Americans (73.1%) and 3 multiracial participants (11.5%).

### *Age*

The total pre-test sample of 51 parents ( $N = 51$ ) ranged in age from 24-57 years. ( $M = 37.59$ ,  $SD = 8.31$ ). The pre-test comparison group ranged in age from 24-52 years ( $M = 36.08$ ,  $SD = 7.762$ ). The pre-test treatment group ranged in age from 24-57 years ( $M = 39.04$ ,  $SD = 8.706$ ).

### *Education Level*

Education level was reported through a question included on the DIT-2. Education levels ranged from completing grades 7-9 through graduate work including

Master's and Professional degrees. Since various education levels were reported, the total pre-test sample's education levels are included in the table below (see Table 5.1).

Table 5.1

<b>Education level of total pre-test sample</b>				
	Frequency	Percent	Valid Percent	Cumulative Percent
Grade 7-9	1	2.0	2.0	2.0
Grade 10-12	10	19.6	20.0	22.0
Vocational/Technical School	15	29.4	30.0	52.0
Junior College	13	25.5	26.0	78.0
Freshman in College	2	3.9	4.0	82.0
Junior in College	1	2.0	2.0	84.0
Senior in College	3	5.9	6.0	90.0
Professional Degree	3	5.9	6.0	96.0
Master's Degree	1	2.0	2.0	98.0
Other	1	2.0	2.0	100.0
Total	50	98.0	100.0	
Total	51	100.0		

The modal education level for the total pre-test sample was Vocational/Technical School with 15 participants reporting this as their highest level of education attained. The categories of Junior College and Grades 10-12 were reported with the second and third highest frequency at 13 and 10 responses respectively. These three levels of education encompassed 74.5% of the total pre-test sample's responses.

### *Family Configuration*

The 39 families that made up the total pre-test sample varied in their configuration. Seventeen families (43.6%) were classified as single-parent families, another 17 were classified as two-parent families (43.6%) and five families (12.8%) were classified as other. Two-parent families included all households with two parents or guardians living in the home. The two-parent category included blended families, step-parents and homes in which there were two non-parent adult guardians such as a grandmother and grandfather, aunt and uncle. Single parent families were classified as families with one parent living in the home. Some families in this study were classified as “Other,” these families were comprised of single familial guardians such as an aunt or grandmother. The 19 pre-test comparison group families included 5 single parent families (26.3%), 11 two-parent families (57.9%) and 3 families classified as other (15.8%). The 20 pre-test treatment group families were made up of 12 single parent families (60%), 6 two-parent families (30%) and 2 families classified as other (10%).

### *Income*

Income level was reported in ranges by each of the 39 families during the intake process. The modal response for income level was 21-40 thousand dollars annually, with 12 respondents reporting their income at this level. Income levels ranged between 0-10 thousand dollars annually to over 100 thousand dollars annually (see Table 5.2). The comparison and treatment group income distributions were similar at pre-test (see Table 5.3, Table 5.4)

Table 5.2

**Income level for total pre-test sample**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0-10k	5	12.8	12.8	12.8
11-20k	7	17.9	17.9	30.8
21-40k	12	30.8	30.8	61.5
41-60k	7	17.9	17.9	79.5
61-80k	3	7.7	7.7	87.2
81-100k	2	5.1	5.1	92.3
100k+	3	7.7	7.7	100.0
Total	39	100.0	100.0	

Table 5.3

**Income level for comparison group at pre-test**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0-10k	3	15.8	15.8	15.8
11-20k	2	10.5	10.5	26.3
21-40k	8	42.1	42.1	68.4
41-60k	4	21.1	21.1	89.5
81-100k	1	5.3	5.3	94.7
100k+	1	5.3	5.3	100.0
Total	19	100.0	100.0	



Table 5.4

**Income level for treatment group at pre-test**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 0-10k	2	10.0	10.0	10.0
11-20k	5	25.0	25.0	35.0
21-40k	4	20.0	20.0	55.0
41-60k	3	15.0	15.0	70.0
61-80k	3	15.0	15.0	85.0
81-100k	1	5.0	5.0	90.0
100k+	2	10.0	10.0	100.0
Total	20	100.0	100.0	

*Number of Children*

The number of children living in the household was reported for all families in this study. The number of children ranged from 1-5 for the total pre-test sample. A summary of the number of children in each family for the total pre-test sample is included below (see Table 5.5).

Table 5.5

**Number of Children in Household total pre-test sample**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1	10	25.6	25.6	25.6
2	14	35.9	35.9	61.5
3	8	20.5	20.5	82.1
4	6	15.4	15.4	97.4
5	1	2.6	2.6	100.0
Total	39	100.0	100.0	

The number of children in each comparison group family ranged from 1-4 with a modal response of 2. Data from the control group pre-test sample is included below (see Table 5.6).

Table 5.6

<b>Number of Children in Household comparison pre-test sample</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	26.3	26.3	26.3
	2	6	31.6	31.6	57.9
	3	5	26.3	26.3	84.2
	4	3	15.8	15.8	100.0
	Total	19	100.0	100.0	

The number of children in the treatment group families ranged from 1-5 with a modal response of 2. Data from the comparison group pre-test sample is included below (see Table 5.7)

Table 5.7

<b>Number of Children in Household treatment pre-test sample</b>					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	25.0	25.0	25.0
	2	8	40.0	40.0	65.0
	3	3	15.0	15.0	80.0
	4	3	15.0	15.0	95.0
	5	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Next, a summary of the total pre-test sample demographic data is presented for individual-level demographic data (see Table 5.8).

Table 5.8

*Summary of Demographics of the Total Pre-Test Sample (Individual)*

Variable	Treatment		Comparison	
	Percentage	<i>n</i>	Percentage	<i>n</i>
Gender				
Female	69%	18	76%	19
Male	31%	8	24%	6
Race				
Caucasian	73%	19	64%	16
Black / African American	15%	4	36%	9
Multiracial / Other	12%	3	0%	0
Education				
Grade 7-9	4%	1	0%	0
Grade 10-12	15%	4	25%	6
Vocational/Technical School	31%	8	29%	7
Junior College	31%	8	21%	5
Freshman in College	0%	0	8%	2
Junior in College	0%	0	4%	1
Senior in College	8%	2	4%	1
Professional Degree	8%	2	4%	1
Master's Degree	0%	0	4%	1
Other	4%	1	0%	0

Note. Pre-Test  $N=51$  (comparison  $n=25$ ; treatment  $n=26$ ). Post-Test  $N=29$  (comparison  $n=13$ ; treatment  $n=16$ ).

*Sample Mortality*

Twenty-two parents ( $n = 22$ ) exited the study prior to post-testing. Of the 22 parents who dropped out of the study prior to post-testing, 12 ( $n = 12$ ) were from the comparison group and 10 ( $n = 10$ ) were from the treatment group. These parents represented 17 ( $n = 17$ ) of the 39 families or 44% of the initially recruited sample of families for this study. Fifty-six percent of families completed both pre and post-test

measures. The final post-test comparison group retained 52% of its initial sample of parents whereas the final post-test treatment group retained 61.5% of its initial sample of parents. The high rate of attrition was expected in this study, as participants were voluntary family counseling clients. Unplanned termination is common in family therapy, with some studies reporting unplanned termination rates as high as 50% (Allgood, Crane & Agee, 1997).

*Analysis of Individual-Level Demographic Variables and Attrition*

A total of 29 participant parents (N = 29) from 22 different families completed this study. Of these 29 participants, 13 (n = 13) parents from 11 families were in the comparison group and 16 (n = 16) parents from 11 families were in the treatment group. A Chi Square test for independence was computed to determine if a differential drop out rate by group existed. The participants showed no significant differences in their rates of attrition by group,  $\chi^2(1, n = 51) = .473, p = .492$  (see Table 5.9).

Table 5.9

**Group \* Complete Crosstabulation**

Count		Complete		Total
		Complete	Not Complete	
Group	Comparison	13	12	25
	Treatment	16	10	26
Total		29	22	51

*Gender*

The total post-test sample included 21 females (n = 21) representing 72% of the sample and 8 males (n = 8) representing the remaining 28% of the total post-test sample.

A Chi-Square test for independence was computed to determine if a differential rate of

attrition existed related to gender. No differential rates of attrition were found related to gender,  $\chi^2(1, n = 51) = .001, p = .980$ . (see Table 5.10). Ten participants, or 77% of the comparison group were female and 3 participants, or the remaining 23% were male. The treatment group was comprised of 11 females and 5 males, 69% and 31% respectively.

Table 5.10

**Complete \* Gender Crosstabulation**

Count		Gender		Total
		Female	Male	
Complete	Complete	21	8	29
	Not Complete	16	6	22
Total		37	14	51

*Race*

The total post-test sample included 18 participants who self-identified as Caucasian, 8 Black/African-American participants and 3 Multiracial/Other participants. The comparison group was made up of 8 Caucasian participants and 5 Black/African American participants. The treatment group was similarly constituted with 10 Caucasian, 3 Black/African American, and 3 Multiracial participants. Race was examined for its potential affect on attrition in both groups. A Chi-Square test for independence revealed no differential drop out rate related to race,  $\chi^2(2, n = 51) = 2.81, p = .245$  (see Table 5.11).

Table 5.11

Race * Complete Crosstabulation				
Count		Complete		Total
		Complete	Not Complete	
Race	African-American/Black	8	5	13
	Caucasian/White/European American	18	17	35
	Multiracial	3	0	3
Total		29	22	51

### Age

The total post-test sample of 29 parents ( $N = 29$ ) ranged in age from 26-57 years. ( $M = 38.83$ ,  $SD = 8.54$ ). The post-test comparison group ranged in age from 28-52 years ( $M = 37.31$ ,  $SD = 7.24$ ). The post-test treatment group ranged in age from 26-57 years ( $M = 40.06$ ,  $SD = 9.51$ ).

### Education

Education was examined as a potential factor affecting attrition. A Chi-Square test for independence revealed no differential in attrition related to education,  $\chi^2(9, n = 51) = 11.05$ ,  $p = .272$ . (see Table 5.12 and Table 5.13).

Table 5.12

**Education \* Complete Crosstabulation**

Count		Complete		Total
		Complete	Not Complete	
Education	Grade 7-9	0	1	1
	Grade 10-12	7	3	10
	Vocational/Technical School	9	6	15
	Junior College	6	7	13
	Freshman in College	0	2	2
	Junior in College	1	0	1
	Senior in College	3	0	3
	Professional Degree	1	2	3
	Master's Degree	0	1	1
	Other	1	0	1
Total		28	22	50

A summary of the demographic data from the post-test groups who completed this study is presented next (see table 5.13).

Table 5.13

*Summary of Demographics of the total Post-Test Sample (Individual)*

Variable	Treatment		Comparison	
	Percentage	<i>n</i>	Percentage	<i>n</i>
Gender				
Female	69%	11	77%	10
Male	31%	5	23%	3
Race				
Caucasian	62%	10	62%	8
Black / African American	19%	3	38%	5
Multiracial / Other	19%	3	0%	0
Education				
Grade 7-9	0%	0	0%	0
Grade 10-12	19%	3	33%	4
Vocational/Technical School	43%	7	17%	2
Junior College	19%	3	25%	3
Freshman in College	0%	0	0%	0
Junior in College	0%	0	8%	1
Senior in College	13%	2	8%	1
Professional Degree	0%	0	8%	1
Master's Degree	0%	0	0%	0
Other	6%	1	0%	0

Note. Pre-Test  $N=51$  (comparison  $n=25$ ; treatment  $n=26$ ). Post-Test  $N=29$  (comparison  $n=13$ ; treatment  $n=16$ ). One comparison group participant did not report education level.

*Analysis of Family-Level Demographic Variables and Attrition*

Thirty-nine ( $N = 39$ ) families made up the total pre-test sample of families recruited for this study. Of these 39 initial families, 17 families exited the study prior to post-testing on all measures. The final sample included 22 families ( $N = 22$ ) with 11 families each ( $n = 11$ ) in the treatment and comparison groups.

*Family Configuration*

A Chi-Square test for independence was computed to determine whether there was a differential rate of attrition based on family configuration. The Chi-Square analysis



revealed no significant differential rates of attrition based on family configuration,  $\chi^2(2, n = 39) = 3.21, p = .201$  (see Table 5.14).

Table 5.14

**Complete \* Configuration Crosstabulation**

Count		Configuration			Total
		Single	Two Parent	Other	
Complete	Yes	7	11	4	22
	No	10	6	1	17
Total		17	17	5	39

*Income*

A Chi-Square test for independence was computed to determine whether those families who completed the study were different from those who exited the study in their level of reported household income. The Chi-Square test for independence revealed no significant differences between completers versus non-completers according to income,  $\chi^2(6, n = 39) = 2.55, p = .862$  (see Table 5.15).

Table 5.15

**Complete \* Income Crosstabulation**

Count		Income							Total
		0-10k	11-20k	21-40k	41-60k	61-80k	81-100k	100k+	
Complete	Yes	3	4	6	4	1	2	2	22
	No	2	3	6	3	2	0	1	17
Total		5	7	12	7	3	2	3	39

*Number of Children*

The number of children in the household ranged from 1-5 in the total post-test sample with a modal response of 2 for the overall sample. A one-way analysis of variance

(ANOVA) was computed to determine if there were differential rates of attrition based on the number of children reported in each household. No significant interaction effects were found by group and completion status,  $F(3, 1) = .012$ ,  $p = .912$  (see Table 5.16) for the number of children reported in each household.

Table 5.16

Tests of Between-Subjects Effects					
Dependent Variable: Kids					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	.076 <sup>a</sup>	3	.025	.019	.996
Intercept	207.421	1	207.421	155.819	.000
Group	.017	1	.017	.012	.912
Complete	.050	1	.050	.037	.848
Group * Complete	.017	1	.017	.012	.912
Error	46.591	35	1.331		
Total	259.000	39			
Corrected Total	46.667	38			

a. R Squared = .002 (Adjusted R Squared = -.084)

#### *Number of Sessions Attended and Time in Therapy*

The number of sessions attended at post-test for those completing the study ranged from 6-25, spanning a length of time ranging from 3-9 months. Families in the treatment group attended between 6 and 25 sessions ( $M = 13.55$ ,  $SD = 6.31$ ) over a period spanning 3-9 months ( $M = 5$ ,  $SD = 2.15$ ). The comparison group families attended between 7 and 16 sessions ( $M = 11.18$ ,  $SD = 2.601$ ) over a period spanning 3-7 months ( $M = 4.55$ ,  $SD = 1.21$ ). A one-way analysis of variance was computed to determine if the groups were differential in their completion rates according to the number of sessions attended. As expected, a significant main effect was discovered for completion as those who completed the study would have logically completed more sessions than those who

dropped out  $F(3,1) = 28.05$ ,  $p = .000$ . No significant interaction effects were discovered for group by completion  $F(3, 1) = .42$ ,  $p = .521$  (see Table 5.17).

Table 5.17

<b>Tests of Between-Subjects Effects</b>					
Dependent Variable: Sessions					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	585.534 <sup>a</sup>	3	195.178	9.867	.000
Intercept	2803.121	1	2803.121	141.702	.000
Group	19.622	1	19.622	.992	.326
Complete	554.806	1	554.806	28.046	.000
Group * Complete	8.310	1	8.310	.420	.521
Error	692.364	35	19.782		
Total	4473.000	39			
Corrected Total	1277.897	38			

a. R Squared = .458 (Adjusted R Squared = .412)

The amount of time in therapy was also examined using a one-way analysis of variance (ANOVA) to determine whether the groups were differential in their completion status related to the amount of time spent in therapy. As expected, a main effect was discovered for completion, as those who completed the study would have logically spent more time in counseling than those who had dropped out  $F(1,35) = 23.18$ ,  $p = .000$ . No significant interaction effects were found for group by completion  $F(1, 35) = .304$ ,  $p = .585$  indicating no differential between groups on the amount of time spent in counseling (see Table 5.18).

Table 5.18

<b>Tests of Between-Subjects Effects</b>					
Dependent Variable: Time					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	65.858 <sup>a</sup>	3	21.953	7.912	.000
Intercept	462.740	1	462.740	166.768	.000
Group	.238	1	.238	.086	.771
Complete	64.311	1	64.311	23.177	.000
Group * Complete	.843	1	.843	.304	.585
Error	97.116	35	2.775		
Total	680.000	39			
Corrected Total	162.974	38			

a. R Squared = .404 (Adjusted R Squared = .353)

#### *Analysis of Pre-Test Scores of Completion and Non-Completion Participants*

After analyzing the descriptive data, this researcher explored whether or not there were significant differences between those who completed the study and those who exited the study prior to post-testing on each of the pre-test measures. One-way analysis of variance (ANOVA) was computed for each of the pre-test measures. The analysis of variance revealed no significant interaction effect between the those who completed the study and those who dropped out by group (treatment, comparison) on the WUSCT,  $F(1, 45) = 1.206$ ,  $p = .278$  (see Table 5.19).

Table 5.19

<b>Tests of Between-Subjects Effects</b>					
Dependent Variable: WUSCT-Pre					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	2.072 <sup>a</sup>	3	.691	1.050	.380
Intercept	1152.663	1	1152.663	1752.277	.000
Complete	1.223	1	1.223	1.860	.179
Group	.315	1	.315	.479	.492
Complete * Group	.793	1	.793	1.206	.278
Error	29.601	45	.658		
Total	1217.000	49			
Corrected Total	31.673	48			

a. R Squared = .065 (Adjusted R Squared = .003)

Analysis of variance computed for pre-test scores on the DIT-2 P index also revealed no significant interaction effects between completion and group,  $F(1, 45) = .461$ ,  $p = .501$  (see Table 5.20).

Table 5.20

<b>Tests of Between-Subjects Effects</b>					
Dependent Variable: DIT-Pre					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	248.197 <sup>a</sup>	3	82.732	.470	.705
Intercept	26946.916	1	26946.916	153.007	.000
Complete	104.545	1	104.545	.594	.445
Group	135.127	1	135.127	.767	.386
Complete * Group	81.130	1	81.130	.461	.501
Error	7925.184	45	176.115		
Total	35694.769	49			
Corrected Total	8173.380	48			

a. R Squared = .030 (Adjusted R Squared = -.034)

Furthermore, no significant interaction effects were found between completion and group for pre-test scores on the DIT-2 N2 score,  $F(1, 45) = .005$ ,  $p = .942$  (see Table 5.21).

Table 5.21

Tests of Between-Subjects Effects					
Dependent Variable: N2 Pre					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	337.785 <sup>a</sup>	3	112.595	.604	.616
Intercept	19298.729	1	19298.729	103.590	.000
Complete	7.204	1	7.204	.039	.845
Group	316.519	1	316.519	1.699	.199
Complete * Group	.989	1	.989	.005	.942
Error	8383.428	45	186.298		
Total	29063.715	49			
Corrected Total	8721.213	48			

a. R Squared = .039 (Adjusted R Squared = -.025)

The Global Assessment of Relational Functioning (GARF) scores were assigned to families at pre and post-testing by their family counselors. Because these ratings were assigned at the level of the family, our sample size was limited to the 22 families (N = 22) included in the final sample. A one-way analysis of variance (ANOVA) was computed to determine if attrition rates were differential for those who completed the study as compared to those who did not complete the study. No significant effects were found,  $F(1, 34) = .330$ ,  $p = .570$  (see Table 5.22) indicating that those families who dropped out of the study did not appear to be any different on their GARF pre-test ratings than those who remained part of the study through post-testing.

Table 5.22

<b>Tests of Between-Subjects Effects</b>					
Dependent Variable: GARF-Pre					
Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	623.826 <sup>a</sup>	3	207.942	1.883	.151
Intercept	138374.139	1	138374.139	1252.706	.000
Group	345.582	1	345.582	3.129	.086
Complete	195.718	1	195.718	1.772	.192
Group * Complete	36.424	1	36.424	.330	.570
Error	3755.648	34	110.460		
Total	147982.000	38			
Corrected Total	4379.474	37			

a. R Squared = .142 (Adjusted R Squared = .067)

### *Summary*

Initial analyses of all pre-test measures indicated no significant differences on pre-test assessment scores related to rates of attrition. No significant main effects for group or completion were found, nor were there any significant interaction effects between group and completion. These analyses are a strong indicator that at pre-testing the groups (treatment and comparison) started out at the same place. Those who left the study prematurely did not appear to be any different than those who completed the study on the three pre-test measures (DIT-2, WUSCT, GARF). Both DIT-2 P-scores and N2 scores were used for the purpose of this study. In addition, no significant differential rates of attrition were found related to the various demographic variables in this study. These findings indicate that attrition was not related to race, gender, level of education, family configuration, number of children in the household or family income.

### *Mean Instrument Scores*

This section will present the mean instrument scores at pre-test and post-test for the comparison and treatment groups on the following assessments: the Defining Issues Test II (DIT-2), the Washington University Sentence Completion Test (WUSCT) and the Global Assessment of Relational Functioning (GARF). Both N-2 and P-scores will be reported for the DIT-2. Descriptions of each instrument as well as normative data and the score results for each group are presented.

#### *The Defining Issues Test-2 (DIT-2)*

The Defining Issues Test-2 was used to measure moral reasoning for the purpose of this study. The DIT-2 produces a P-score that indicates the degree to which respondents use the post-conventional schema. For the purpose of this study both P and N2 scores were examined. The P score ranges from 0 to 95 with lower scores indicating lower levels of moral reasoning. The N2 score is based on the P score, but also considers whether the tester is able to rank post-conventional choices as more important than conventional choices when rating items for each dilemma (Thoma, 2006). The N2 score is highly correlated with the P-score. Normative data for the DIT-2 is provided based on education level. Since over 75% of the sample for this study reported their highest level of education attained as either grades 10-12, vocational/technical school or junior college, the norms for these three education levels will be provided in the discussion below.

The mean P-scores and N2 scores at pre and post-testing for both the comparison and treatment groups are presented in Table 5.23. Mean DIT-2 P scores were nearly equivalent at pre-testing for both the comparison and treatment group. At post-testing the comparison group mean remained relatively stable while the treatment group mean



increased nearly 9 points. The Mean DIT-2 P scores at pre-testing were lower than the normative data reported for the DIT-2 (Thoma, 2006). Normative data for the DIT-2 P score for individuals having completed grades 10-12 indicate  $M = 33.13$ ,  $SD = 17.04$ , and  $M = 32.19$ ,  $SD = 15.19$ ,  $M = 31.06$ ,  $SD = 14.22$  for those who completed vocational or technical school or junior college respectively. At post-testing the treatment group Mean DIT-2 P scores were approximately equivalent with the normative data provided for groups with similar education levels whereas the comparison group remained nearly 10 points below the normative means.

The N2 score means at pre-testing for both groups were also smaller than the means presented in the normative data for respondents with similar education levels. Normative data for the DIT-2 N2 score indicate  $M = 31.69$ ,  $SD = 17.18$  for individuals who completed grades 10-12, and  $M = 28.7$ ,  $SD = 17$ ;  $M = 29.48$ ,  $SD = 15.09$  for those who completed vocational or technical school or junior college respectively. At post-testing both groups demonstrated an increase in their N2 Mean scores with the comparison group mean increasing by just over three points and the treatment mean increasing by over eight points. The comparison group remained below the normative mean for N2 scores at post-testing  $M = 20.94$ ,  $SD = 16.50$ , while the treatment group mean moved within the range of normative means for participants with similar education levels  $M = 30.12$ ,  $SD = 15.08$ .

#### *The Washington University Sentence Completion Test (WUSCT)*

Ego development was measured using the 18-item short-form WUSCT. Each participant completed the appropriate gender specific form (see Appendix B). The principal researcher scored all of the WUSCTs with another doctoral candidate after

participating in rigorous self-training procedures as outlined in *Measuring Ego Development* (Hy & Loevinger, 1996). Inter-rater reliability was established with an expert rater. Across the 18 item stems, a 93.8% agreement level was achieved between Rater 1 and Rater 2, and a 90% agreement level was achieved for the total protocol rating (TPR).

Ego levels, as measured by the WUSCT, range from Impulsive (E2) to Integrated (E9). Data from this study included 5 ego levels in its range, from Self-Protective (E3) through Individualistic (E7). The lowest, Impulsive (E2) level and the two highest levels, Autonomous (E8) and Integrated (E9) were not represented in this sample.

The WUSCT was originally normed using a population solely comprised of women (Loevinger, 1976). Specific normative data on the WUSCT is difficult to find, however, when the WUSCT was revised for use with men and women, the mean ego score was found to be 5.75 for women ( $SD = 1.46$ ) and 5.58 ( $SD = 1.25$ ) for men with an overall reported mean of  $M = 5.68$ . Mean scores for the comparison group on the WUSCT at pre-testing indicated an average ego level of  $M = 4.85$ ,  $SD = .689$  which increased slightly to  $M = 5.00$ ,  $SD = .707$  at post-testing. The treatment group mean was similar to the comparison group mean at pre-testing with an average ego level of  $M = 4.75$ ,  $SD = .931$ . The treatment group mean ego level rose to  $M = 5.50$  ( $SD = 1.10$ ) at post-testing, bringing the post-test mean closer to normative data provided for adult men and women. Summaries of the pre and post-test WUSCT data by group are provided in table 5.23.

*The Global Assessment of Relational Functioning (GARF)*

Families in the comparison group entered counseling with a mean GARF rating of  $M = 67.33$  ( $SD = 12.16$ ), slightly higher than the mean GARF rating for families in the treatment group  $M = 58.00$ ,  $SD = 8.41$ . At post-testing, the comparison group's mean GARF scores were slightly lower, while the treatment group means were slightly higher. The comparison group reported a post-test mean of  $M = 67$ ,  $SD = 15.41$  and the treatment group reported a post-test mean of  $M = 63.78$ ,  $SD = 13.21$ . No normative data have been established for the GARF. A summary of the pre and post-test GARF data for both groups is presented below (see Table 5.23).

Table 5.23

*Mean Instrument Scores By Group*

Variable	Comparison		Treatment	
	Pre-Test <i>M / SD</i>	/ Post -Test <i>M / SD</i>	Pre-Test <i>M / SD</i>	/ Post -Test <i>M / SD</i>
DIT-2 P	22.31 / 16.12	22.72 / 14.12	23.08 / 12.19	32.00 / 14.44
DIT-N2	17.32 / 15.12	20.94 / 16.50	22.85 / 14.43	30.12 / 15.08
WUSCT	4.85 / .689	5.00 / .707	4.75 / .931	5.50 / 1.10
GARF	67.33 / 12.16	67.00 / 15.41	58.00 / 8.41	63.78 / 13.21

Note. Pre-Test (Individual Participants)  $N=51$  (comparison  $n=25$ ; treatment  $n=26$ ). Post-Test (Individual Participants)  $N=29$  (comparison  $n=13$ ; treatment  $n=16$ ). Pre-Test (Families)  $N=39$  (comparison  $n=19$ ; treatment  $n=20$ ). Post-Test (Families)  $N=22$  (comparison  $n=11$ ; treatment  $n=11$ ). Equal Variances Assumed.

### *Formal Analysis of Research Hypotheses*

The following three hypotheses formed the foundation of this study. Each hypothesis is formally analyzed and its results discussed. A discussion of the implications of each finding is presented in chapter six.

#### *Hypothesis I.*

Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in moral development as measured by the Defining Issues Test (DIT-2) when compared with parents of families receiving SFT alone.

#### *Hypothesis II.*

Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in ego development as measured by the Washington University Sentence Completion Test (WUSCT) when compared with parents of families receiving SFT alone.

#### *Hypothesis III.*

Parents of families receiving Structural Family Therapy with the addition of a DPE intervention will show an increase in relational functioning as measured by the Global Assessment of Relational Functioning when compared with parents of families receiving SFT alone.

### *Results*

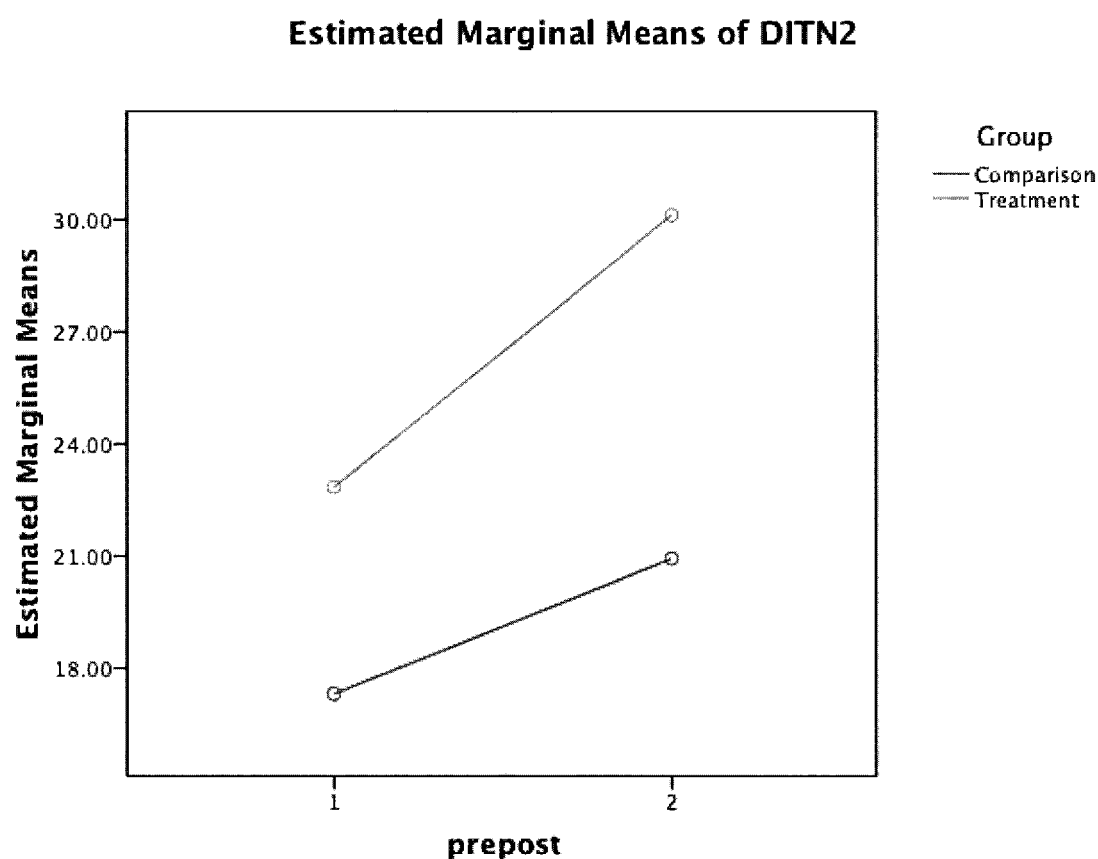
#### *Repeated Measures MANOVA*

##### *Hypothesis I.*

A 2 x 2 repeated measures MANOVA was computed to determine if the effects of Structural Family Therapy with the addition of the DPE intervention significantly raised

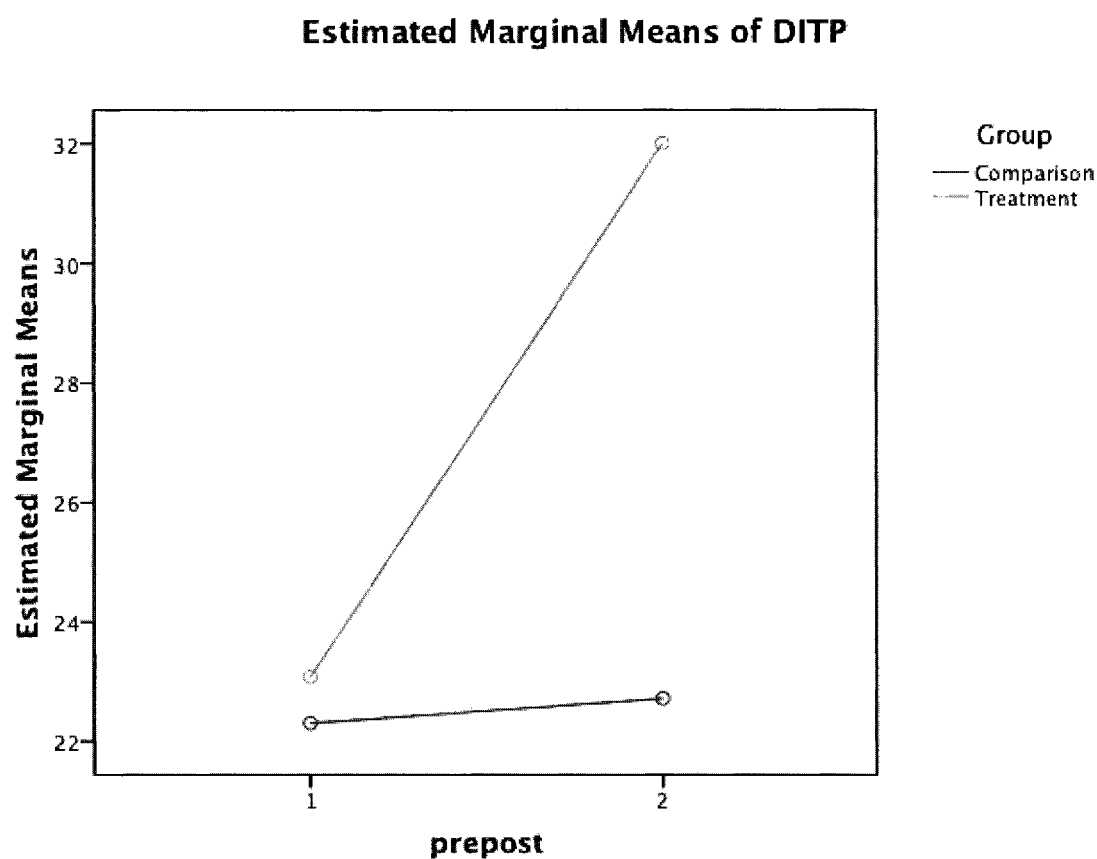
moral reasoning in parents as measured by the DIT-2 when compared with parents receiving family therapy alone. This analysis examined both the DIT-2 P-scores as well as the DIT-2 N2 scores. The results of this MANOVA indicated a significant main effect for Time for the DIT-2 N2 scores [ $F(1, 27) = 5.752, p = .024$ ] indicating that both groups demonstrated significantly raised moral reasoning as measured by the DIT-2 N2 scores over time. No significant main effect for Group was found [ $F(1, 27) = 1.988, p = .170$ ] and no significant interaction effect (Time x Group) was found for the N2 scores [ $F(1, 27) = .644, p = .429$ ]. Figure 5.1 demonstrates the parallel growth in N2 scores experienced by the treatment and comparison groups. A moderate overall effect size was achieved for the N2 scores ( $d = .506$ ).

Figure 5.1



The analysis of the P-index indicated no significant main effect was established for Time [ $F(1, 27) = 3.993, p = .056$ ] or Group [ $F(1, 27) = 1.117, p = .300$ ] and no significant interaction effect was established for Time by Group [ $F(1, 27) = 3.314, p = .080$ ]. While no significant interaction effect was found for Time by Group for the DIT-2 P scores upon initial analysis, a review of group means for the P-index at pre and post-testing indicated a large increase in means from pre to post-testing in the treatment group. Examining the plot of estimated marginal means for the DIT-2 P index suggested a significant interaction effect between time and group (see Figure 5.2).

Figure 5.2



A variance violation was discovered and led this researcher to conduct a follow-up test in which equality of variance was no longer assumed. A Games-Howell procedure confirmed the pattern observed in the increased P-scores for the treatment group and significance was achieved (Games & Howell, 1976; Field, 2005). A review of the summary of means table (Table 5.23) demonstrates the significant increase in P-score means from pre to post-test in the treatment group. A moderately large effect size was found for the DIT-2 P index ( $d = .673$ ) by calculating Cohen's D as outlined in

Thalheimer and Cook (2002). This finding supports this study's first hypothesis, indicating that parents who received family therapy with the DPE intervention increased their moral reasoning significantly as compared to those parents receiving the comparison group family therapy condition. This study considered both the P score and the N2 score. It should be noted that "the major impact of the N2 score is with older and presumably more developed individuals because it should be most helpful in discriminating at the high end of the developmental scale" (Thoma, 2006, p. 81). When one considers the pre-test means for both groups, even in relation to the DIT-2's normative data, it is clear that this study's sample was not situated at the high end of the developmental scale. This may explain the lack of significance over time by group of the N2 scores. The P-index did show significant growth for the treatment group and this researcher feels that the P-index is sufficient in measuring moral reasoning for this study's sample. In summary, Hypothesis I. was partially supported, with significant change indicated for the treatment group on the P-index across time, and with significant change indicated on the N2 index for both groups across time.

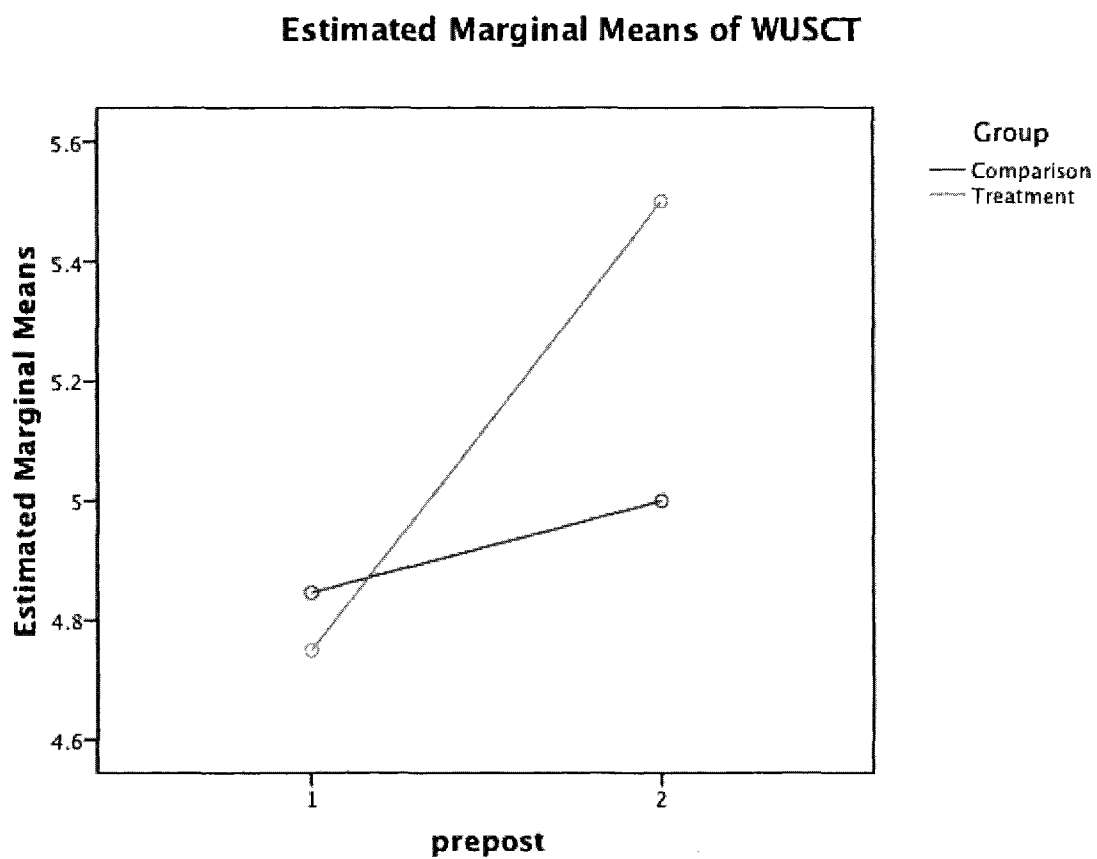
#### Hypothesis II.

A 2 x 2 repeated measures MANOVA was computed to determine if the effects of Structural Family Therapy with the addition of the DPE intervention significantly raised ego development as measured by the WUSCT when compared with parents receiving family therapy alone. The results of this analysis indicated a significant main effect for Time [ $F(1,27) = 18.2, p = .000$ ] as well as a significant interaction effect for Time x Group [ $F(1,27) = 7.918, p = .009$ ]. No significant main effect was found for Group [ $F(1,27) = .412, p = .526$ ]. These results indicate that both groups showed growth in their



ego development as measured by the WUSCT, but that the treatment group demonstrated significantly more growth in ego development than the comparison group at post-testing, indicating support for the second hypothesis. A moderate overall effect size of ( $d = .5479$ ) was found by calculating Cohen's  $D$  as outlined in Thalheimer and Cook, (2002). Effect size was also calculated for the gain in treatment group means over time, which indicated a large effect size ( $d = .736$ ), for the treatment condition. A review of the plot of the estimated marginal means of the WUSCT confirms this significant interaction visually (see Figure 5.3). In summary, Hypothesis II. was supported, with a significant interaction effect across time and group which indicated that the treatment group demonstrated significant growth across time as compared to the comparison group.

Figure 5.3



The following tables provide a summary of the within and between subjects factors for the first two hypotheses (see Tables 5.24, 5.25). The third hypothesis is analyzed separately as GARF scores were given at the level of the family.

Table 5.24

## Tests of Within-Subjects Contrasts

Source	Measure	prepost	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squar ed	Noncent Param.	Obs. Power <sup>a</sup>
prepost	WUSCT	Linear	2.930	1	2.930	18.200	.000	.403	18.200	.984
	DITP	Linear	312.578	1	312.578	3.993	.056	.129	3.993	.487
	DITN2	Linear	424.782	1	424.782	5.752	.024	.176	5.752	.638
prepost * Group	WUSCT	Linear	1.275	1	1.275	7.918	.009	.227	7.918	.774
	DITP	Linear	259.423	1	259.423	3.314	.080	.109	3.314	.419
	DITN2	Linear	47.525	1	47.525	.644	.429	.023	.644	.121
Error (pre post)	WUSCT	Linear	4.346	27	.161					
	DITP	Linear	2113.352	27	78.272					
	DITN2	Linear	1994.008	27	73.852					

a. Computed using alpha = .05

Table 5.25

**Tests of Between-Subjects Effects**

Transformed Variable: Average

Source	Measure	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Param.	Obs. Power <sup>a</sup>
Intercept	WUSCT	1448.309	1	1448.309	1019.772	.000	.974	1019.772	1.000
	DITP	35941.112	1	35941.112	110.839	.000	.804	110.839	1.000
	DITN2	29843.063	1	29843.063	76.379	.000	.739	76.379	1.000
Group	WUSCT	.585	1	.585	.412	.526	.015	.412	.095
	DITP	362.115	1	362.115	1.117	.300	.040	1.117	.175
	DITN2	776.876	1	776.876	1.988	.170	.069	1.988	.275
Error	WUSCT	38.346	27	1.420					
	DITP	8755.128	27	324.264					
	DITN2	10549.482	27	390.722					

a. Computed using alpha = .05

**Hypothesis III.**

A 2 x 2 repeated measures ANOVA was computed to determine if the effects of Structural Family Therapy with the addition of the DPE intervention significantly improved relational functioning as measured by the GARF when compared with parents receiving family therapy alone. The results of this analysis indicated no significant main effects for Group [ $F(1,31) = 2.532, p = .122$ ], or Time [ $F(1, 31) = 2.257, p = .143$ ]. No significant interaction effect (Time by Group) was found [ $F(1, 31) = 2.844, p = .102$ ]. These results suggest that no significant change in relational functioning occurred between pre and post-testing for either group. No significance within or between factors

was demonstrated and this may be in part due to the small sample size ( $N = 22$ ). The observed power for this test was between .3 for Time and .4 for the interaction.

Summaries of between and within-subjects effects are presented below (see Tables 5.26, 5.26).

By reviewing the plot of the estimated marginal means, it is clear that the treatment group exhibited some gains in relational functioning whereas the comparison group appears to have trended slightly downward from pre to post-testing (see Figure 5.4). Effect size was calculated using formulas for Cohen's  $D$  as outlined in Thalheimer and Cook (2002) and was found to be moderate for the change in GARF within the treatment condition ( $d = .5219$ ). The overall effect size for the post-test means between groups was negative ( $d = -.235$ ). This negative effect size was present because the post-test mean for the treatment group was lower than the mean for the comparison group. The comparison group started the study with higher GARF scores and trended slightly downward, while the treatment group began the study with slightly lower GARF scores and trended upward. In summary, Hypothesis III. was not supported by the results of this study as no significant main effects or interaction effects were present, however, it may be useful to note that a moderate effect size was obtained for the treatment group mean difference across time.

Figure 5.4

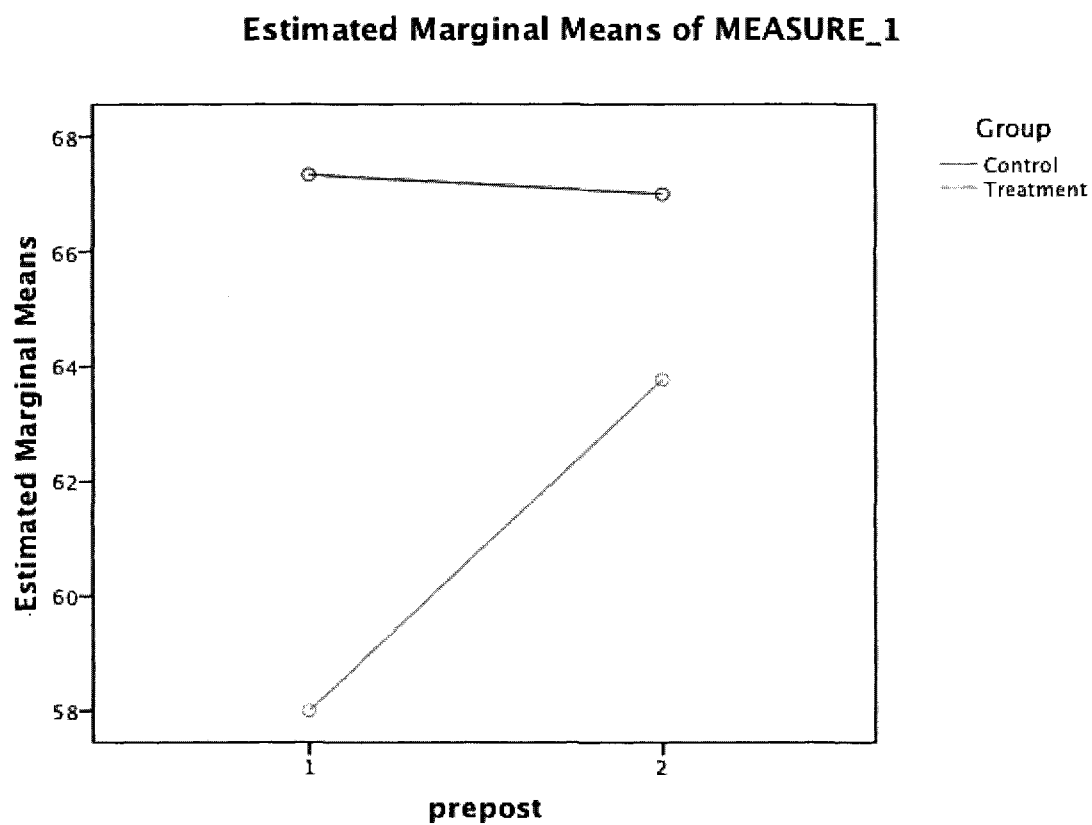


Table 5.26

### Tests of Between-Subjects Effects

Measure: GARF

Transformed Variable: Average

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Noncent. Parameter	Observed Power <sup>a</sup>
Intercept	268334.596	1	268334.596	1053.329	.000	1053.329	1.000
Group	644.899	1	644.899	2.532	.122	2.532	.338
Error	7897.222	31	254.749				

a. Computed using alpha = .05

Table 5.27

**Tests of Within-Subjects Effects**

Measure: GARF

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Noncent. Parameter	Observed Power <sup>a</sup>
prepost	Sphericity Assumed	121.263	1	121.263	2.257	.143	2.257	.307
	Greenhouse-Geisser	121.263	1.000	121.263	2.257	.143	2.257	.307
	Huynh-Feldt	121.263	1.000	121.263	2.257	.143	2.257	.307
	Lower-bound	121.263	1.000	121.263	2.257	.143	2.257	.307
prepost * Group	Sphericity Assumed	152.778	1	152.778	2.844	.102	2.844	.372
	Greenhouse-Geisser	152.778	1.000	152.778	2.844	.102	2.844	.372
	Huynh-Feldt	152.778	1.000	152.778	2.844	.102	2.844	.372
	Lower-bound	152.778	1.000	152.778	2.844	.102	2.844	.372
Error(prepost)	Sphericity Assumed	1665.222	31	53.717				
	Greenhouse-Geisser	1665.222	31.000	53.717				
	Huynh-Feldt	1665.222	31.000	53.717				
	Lower-bound	1665.222	31.000	53.717				

a. Computed using alpha = .05

*Correlational Analysis*

A correlational analysis was run to examine whether a relationship existed between scores on the WUSCT and levels of income and education. No significant relationship was found between a family's reported level of income and scores on the WUSCT. A significant positive relationship was determined to exist between the reported level of education and scores on the WUSCT at both pre ( $r = .289, p = .046$ ) and post-testing ( $r = .432, p = .022$ ). This finding is consistent with research literature on the WUSCT that has demonstrated positive correlations between verbal fluency and higher ego levels as measured by the WUSCT (Gilmore & Durkin, 2001). While education level is not necessarily indicative of verbal fluency, for the purpose of this study it was the

closest indicator and appeared to influence ego levels in similar ways. Fortunately, both groups were similarly constituted and attrition across groups according to education level was not differential.

Three of the research questions posited at the onset of this study asked whether or not relationships existed among the three domains examined in this study. Correlational analyses were run to determine these relationships. Two of these analyses were straightforward, as their measures were on the individual level, however, running a correlational analysis with the GARF data proved challenging. The GARF data was provided at the level of the family, and some of the families in this study had more than one parent. When this was the case, both parents in the family received the same GARF score. This limited variance in the total sample of GARF scores and made interpretation of any significant relationship difficult. Significant correlations existed for each of the measure's pre and post-test scores. For example, GARF pre-test scores were significantly correlated with GARF Post-test scores ( $r = .685, p = .000$ ), DIT-2 P Pre-test scores were significantly correlated with DIT-2 P Post-test scores ( $r = .588, p = .001$ ). A significant relationship was indicated between the GARF scores at pre-test and the N2 scores at pre-test ( $r = .315, p = .029$ ), however this relationship was not indicated when only those who completed the study were analyzed ( $r = .339, p = .072$ ).

Additional significant correlations were indicated between the WUSCT scores at pre-test and the DIT at both pre and post-test ( $r = .412, p = .004$ ) and ( $r = .404, p = .030$ ) respectively. The WUSCT pre-test scores were significantly positively correlated with all other measures except the GARF at post-test when the total pre-test sample was correlated with the total post-test sample. This finding appears to suggest that ego levels



at pre-testing (prior to any type of intervention or comparison treatment) were related to both the pre-test and post-test scores on all other measures when the total initial sample was included in the correlational analysis. This finding is consistent with ego development literature, which suggests that one's ego level may place a ceiling on other domains of development (Snarey, 1998). An additional correlation was run that included just those participants who completed the study. This analysis indicated the same significant positive relationships between various pre and post-test measures as listed above, but also differentiated the total pre-test sample from the pre-test sample that completed the study. When only those participants who completed the study were included in the correlational analysis, the only positive relationships at pre-testing included the DIT-2 P score with the GARF ( $r = .391, p = .036$ ) and the DIT-2 P score with the DIT-2 N2 score ( $r = .852, p = .000$ ).

Scores on the DIT-2 P index were clearly correlated with scores on the DIT-2 N2 index at both pre and post-testing, a finding consistent with research on the two types of scores produced by the DIT-2 (Thoma, 2006). Interestingly, the WUSCT scores at post-test were only significantly correlated with the DIT-2 P scores at post-test ( $r = .415, p = .025$ ), a finding consistent with the support of this study's first two hypotheses. A summary of the correlations run with this data set is presented below (see Table 5.28).

Table 5.28

## Correlations

		GARF Pre	GARF Post	WUSCT Pre	WUSCT Post	DIT Pre	DIT Post	N2 Pre	N2 Post
GARF- Pre	Pearson Correlation	1	.685**	.227	.056	.262	-.041	.315*	.061
	Sig.		.000	.120	.774	.072	.834	.029	.751
	N	50	43	48	29	48	29	48	29
GARF- Post	Pearson Correlation	.685**	1	.318*	.177	.106	.034	.205	.181
	Sig.	.000		.040	.358	.511	.863	.198	.347
	N	43	43	42	29	41	29	41	29
WUSCT- Pre	Pearson Correlation	.227	.318*	1	.757**	.412**	.404*	.343*	.375*
	Sig.	.120	.040		.000	.004	.030	.018	.045
	N	48	42	49	29	47	29	47	29
WUSCT- Post	Pearson Correlation	.056	.177	.757**	1	.110	.415*	.108	.359
	Sig.	.774	.358	.000		.571	.025	.576	.056
	N	29	29	29	29	29	29	29	29
DIT-Pre	Pearson Correlation	.262	.106	.412**	.110	1	.588**	.832**	.627**
	Sig.	.072	.511	.004	.571		.001	.000	.000
	N	48	41	47	29	49	29	49	29
DIT-Post	Pearson Correlation	-.041	.034	.404*	.415*	.588**	1	.564**	.865**
	Sig.	.834	.863	.030	.025	.001		.001	.000
	N	29	29	29	29	29	29	29	29
N2 Pre	Pearson Correlation	.315*	.205	.343*	.108	.832**	.564**	1	.697**
	Sig.	.029	.198	.018	.576	.000	.001		.000
	N	48	41	47	29	49	29	49	29
N2 Post	Pearson Correlation	.061	.181	.375*	.359	.627**	.865**	.697**	1
	Sig.	.751	.347	.045	.056	.000	.000	.000	
	N	29	29	29	29	29	29	29	29

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

### *Summary*

This chapter presented an overview of the demographic data collected for this study including a detailed description of the total pre-test and post-test samples. Analyses were computed to determine if attrition rates were differential between groups and among the various demographic categories. No significant differences were found between those who exited the study and those who completed the study. Means scores across all three assessments were reported for both pre and post-tests for both the comparison and treatment group. Each research hypothesis was formally analyzed using the General Linear Model and repeated measures analysis of variance (ANOVA) and multivariate analysis of variance (MANOVA). Results indicate both the treatment and control group demonstrated gains in ego development as measured by the WUSCT, with a significant main effect demonstrated for Time and a significant interaction effect indicated for Time x Group. A significant main effect for Time was indicated for the DIT-2 N2 scores. Both groups demonstrated increased N2 scores over time, but no interaction effect was demonstrated at the Time by Group level. While no significant main or interaction effects were indicated for the DIT-2 P-scores, further analysis confirmed that there was, in fact a significant interaction effect at the Time x Group level, with the treatment group demonstrating significantly higher gains in moral reasoning at post-test than the comparison group. Families did not appear to significantly change in terms of their relational functioning as measured by the GARF in this study. No main effects or interaction effects were demonstrated in the analysis of GARF scores. Sample size may have contributed to the lack of significant findings for the GARF analysis as only 22 families ( $N = 22$ ) were represented in the final sample of families. A plot of the estimated

marginal means indicates that the treatment group trended upward in their relational functioning over time whereas the comparison group appeared to trend downward.

Correlational analyses indicated significant positive relationships between ego level at pre-test as measured by the WUSCT, and scores on all other indices at both pre and post-testing. The GARF at pre-test was correlated positively with N2 scores at pre-test and with itself at post-test. Because the GARF scores were indicated at the level of the family unit, it is important to note that its level of measurement affects all significant relationships found for the GARF. This occurred because families with more than one parent reported the same GARF score twice, reducing the variance in the sample of GARF scores. While formal analysis of the relationship between relational functioning and the domains of moral reasoning and ego development was not fully possible without an unacceptable level of error, it appears that relational functioning was not related to moral reasoning or ego development in this study.

This chapter presented the results of this study including a summary of demographic information, a thorough description of the sample and formal analysis of each of this study's research hypotheses. The following chapter will explore the findings presented in these analyses and will begin to detail their implications and provide suggestions for future research. Strengths and limitations of this study will be reviewed.

## CHAPTER SIX

### *Discussion*

Raising a family is a complicated task. The recent transition from what has been termed the *modern* era into the current *postmodern* era ushered in new beliefs about the very nature of reality and how family life is constructed (Carter & McGoldrick, 2005; Mills & Sprenkle, 1995). Constructivist viewpoints have transformed the landscape of what is considered to make up the “normal” family lifecycle (Walsh, 2003). Our definitions of family life are no longer anchored to absolute ideals or singular realities, and our constructions of family values have become a more personally and privately situated set of beliefs. This is not to say that community, work, religion and other systems and institutions outside of the family have no impact on family life, but that increasingly, families are tasked with making sense of the world without the fixed standards of right and wrong that have provided guidance and structure for prior generations (Vetere, 2001; Mills & Sprenkle, 1995).

While the landscape of American family life has continued to transform, public policy has lagged in its support of multiple forms of families (Anderson, 1999; Carter & McGoldrick, 2005). The larger social context in which the dynamic family system exists has only recently been re-examined in order to evaluate what is considered normative in terms of family development (Walsh, 2003). Coupled with the multitude of family stressors and lifecycle transitions, a general lack of support for the family system makes for a difficult environment in which to raise children. Many families seek help as they struggle to make sense of their worlds. Historically, family therapists and other mental

health service providers have worked to support families as they face their challenges in times of transition. Family therapy offers a unique systemic perspective on familial struggles and it is in this context that the current study was framed. With the shift from modernist views of therapy to more socially constructed ideas, the field has moved “away from an emphasis on behavior and toward a focus on personal meaning” (Mills & Sprenkle, 1995, p. 369). This study presented a new approach to clinical work with families by making developmental growth the intentional and explicit aim of therapy. A focus on personal meaning and each individual family’s unique struggles formed the backdrop for the task of making sense of new roles, rules and patterns of family communication in this model. As family members were encouraged to interact with each other in new and challenging ways, the relational context of the family became the fertile ground for developmental shifts.

#### *The Cognitive Developmental Framework*

This study’s explicit aim was to facilitate growth in the domains of moral reasoning and ego development while simultaneously supporting families to enhance their relational functioning. The cognitive developmental framework is based upon the premise that individuals use cognitive internal structures to make sense of their environment. These structures are used to organize and adapt to the environment through a series of sequential, hierarchical stages that progress in an invariant sequence (Sprinthall, 1978; Wadsworth, 1978). As individuals progress through these increasingly complex meaning making structures they attempt to gain mastery over themselves and their environment (Sprinthall, Peace & Kennington, 1999). Cognitive developmental growth is not automatic, and in adults, opportunities for growth must be deliberately

facilitated (Sprinthall, 1994). One's developmental stage is conceptualized as a current preference that is open to change, suggesting that developmental change can and does occur in adulthood (Hayes, 1994). Higher levels of development have been associated with more adequate meaning making structures that provide the opportunity for greater tolerance, adaptability and flexibility (McNeel, 1994). Developmental growth becomes particularly important for parents, who act as social and moral guides for their children's development (Walker & Taylor, 1991). Current research literature supports the link between parental influence and moral and ego development in children (Royal & Baker, 2005; Walker & Hennig, 1991; Noam, 1998; Manners, Durkin & Nesdale, 2004). The research literature suggests that higher levels of moral reasoning and ego development may serve as protective factors, providing individuals with a repertoire of adaptive tools that allow for increased perspective taking and flexibility (Noam, 1998).

Cognitive developmental theory has informed this study and was the foundation upon which the treatment condition was built. The DPE intervention designed for this study focused explicitly on the five components laid out by Sprinthall and Mosher (1978) as necessary for facilitating developmental growth: a significant role-taking experience, a balance of action and reflection, a balance of support and challenge, an active, reflective component and an emphasis on continuity. Twenty families were recruited to take part in the treatment group and nineteen families participated in a comparison group that received family therapy without the addition of the DPE intervention. The DPE-intervention offered a fresh perspective on facilitating client change as it explicitly focused on developmental growth in parents, an area largely neglected in the body of developmental research literature.

This study was designed to test the efficacy of a deliberate psychological education (DPE) intervention used in the context of family therapy. Moral reasoning, ego development and relational functioning were the three domains this intervention targeted. Families were referred to counseling through local school personnel for various presenting issues related to the struggles of individual children. The DPE intervention provided structure and specific content for each family therapy session, while allowing enough flexibility for counselors to provide treatment specific to their individual clients' needs. The comparison group in this study engaged in the same general type of family therapy as the treatment group but without the structured guidelines of the DPE intervention. The DPE intervention emphasized discussions about issues of justice and fairness, empathy, rules, roles, decision-making strategies and moral dilemma exercises. Families engaged in the DPE intervention participated in weekly journaling and reflecting exercises. These families attended 10 sessions of family therapy in which an emphasis was placed on the five components of the DPE-approach outlined above. A detailed description of the intervention designed for this study is provided in Chapter Four. While the comparison group families participated in the same significant role-taking experience (participating in family counseling) and undoubtedly received similar levels of support and challenge as their treatment group counterparts, an explicit emphasis on reflection, balance and continuity was not part of their counseling experience. This researcher believes that the focus on reflection and the emphasis on dilemma discussions, problem solving and empathy were the key components that contributed to the success of this intervention.



### *Results and Implications*

This study sought to understand the relationship between an implemented DPE intervention in the context of family therapy and shifts in moral reasoning, ego development and relational functioning. Specifically, this researcher hypothesized that the treatment group receiving the DPE enhanced family therapy would show significantly larger increases in moral reasoning, ego development and relational functioning than the comparison group that did not take part in the DPE enhanced family therapy. The results of this study point toward support for two of the three research hypotheses posited by this researcher. Participants in the treatment group demonstrated significant gains in their moral reasoning and ego development with moderate to large effect sizes indicated for both domains. No significant gains in relational functioning were found for either group.

#### *Ego Development*

Results of this study indicate that both the treatment and comparison groups showed significant change over time in their levels of ego development. This finding suggests that family therapy, in and of itself, may be useful in promoting developmental gains in the domain of ego development. When one considers the relational nature of family therapy, this finding is not surprising. Ego development is facilitated through experiences that are personally relevant and interpersonal in nature, two conditions often met by the experience of counseling. Family counseling offers an interpersonal context in which families can explore new alternatives in a personally relevant and safe environment. While gains in ego level were found for both groups, the treatment group showed even greater gains than the comparison group. A significant interaction effect was found for time and group on the WUSCT, suggesting that while both groups' ego

levels increased, the treatment group's ego levels increased significantly more than the comparison group.

Ego development has been conceptualized as a series of nine sequential stages that represent increasingly complex constructions of the relationship of self and others (Hy & Loevinger, 1996). The participants in this study ranged from the Self-Protective stage (E3) through the Individualistic stage (E7). The average ego level in normative data for adult men and women on the WUSCT indicates a mean ego level of  $M = 5.68$ . Both the treatment and comparison group participants began the intervention with mean ego levels between the Conformist (E4) and Self-Aware stage (E5). The Conformist stage is characterized by a need for social approval and acceptance and includes an emphasis on the importance of rules, law and order. Group membership and acceptance is important at the Conformist stage, and relationships with others are not yet viewed in the context of the feelings and emotions they evoke. The Self-Aware stage is typified by a relational emphasis on both feelings and behavior. At the Self-Aware stage individuals have a clearer sense of differentiation between themselves and others/groups. An emerging sense of multiple perspectives begins to surface at this stage. Capacity for introspection and self-examination become more apparent at this stage.

The differences between the Conformist stage and the Self-Aware stage are important to note in this study as they represent a useful summary of qualitative descriptors of the developmental gains participants in this study experienced. In terms of their shifts in ego level, parents in this study appeared to move from a more dualistic, socially-normed sense of right and wrong in which little tolerance of individual differences was present to a burgeoning understanding of multiple possibilities, self-

awareness and self-other differentiation. Significant growth occurred within both groups, but particularly within the treatment group. At post-testing the average ego level in the treatment group was raised from  $M = 4.75$  ( $SD = .931$ ) to  $M = 5.50$  ( $SD = 1.1$ ). A moderately large effect size ( $d = .736$ ) was calculated for the gain in treatment group means, with a moderate overall effect size calculated between the groups ( $d = .541$ ).

It appears that the DPE-treatment condition provided an enhanced environment for promoting developmental shifts as compared to the comparison group's therapeutic condition. This finding is congruent with previous research literature that supports the use of intentional programs as effective in promoting ego development gains (Manners, Durkin & Nesdale, 2004). Development is possible when there is sufficient exposure to experiences that are disequilibrating, personally salient, emotionally engaging and interpersonal (Manners, Durkin & Nesdale, 2004). With its explicit focus on perspective taking, dilemma discussions and reflective exercises, the intervention developed for this study appeared to provide a structured environment in which families could "try on" new ways of relating to each other.

Families in the treatment group were asked to engage in dilemma discussions and problem solving exercises that encouraged each family member to begin to reflect on their experience as both an individual and as a member of the family unit. The empathy exercise included in the treatment condition asked family members to share with each other a time during which they felt deeply understood. This exercise gave family members the opportunity to share their own unique perspectives and to begin to gain perspective on themselves in relation to the other members of the family. Counselors in the treatment group paid careful attention to providing a therapeutic environment that was

both reflective and continuous. These counselors focused heavily to the reflection exercises assigned to the parent(s) at the end of each session as a way to provide both a contemplative and continuous experience for the family. Supervisors actively examined the counselors' work with clients to ensure that the balance between support and challenge was appropriate for each family's unique developmental needs. It seems that the treatment condition in this study may have provided a more emotionally engaging and personally salient environment than the comparison group therapy through its intentional emphasis on reflection, continuity, support and challenge.

Gains in ego level attend to issues of nurturance and care that may not be as easily recognized within the realm of moral development. Ego development and moral reasoning complement each other well when one places importance on issues of both macro and micro morality. Moral reasoning as conceptualized by Kohlberg focuses largely on issues of justice and fairness that appear at first glance to apply almost completely to the realm of macromorality. Macromorality is characterized by its focus on the formal societal structures involved in fostering social cooperation whereas micromorality concerns itself primarily with how one creates and makes sense of relationships with others and subsequently develops an internalized set of values and virtues. While the two spheres of morality are distinct and at times at odds with each other, they inform one another and must be considered collectively. Where macromorality casts a wide net and places emphasis on societal ideals of cooperation, micromorality acts as the foundation for these ideals in its concentration on the development of interpersonal relationships and an internalized sense of right and wrong. Without the ability to consider the perspectives of others, a quality this researcher feels is

developed through the process of learning to create and make sense of interpersonal relationships, larger-scale societal concerns appear abstract and separate from an individual's lived experience. The results of this study provide support for the notion that both micro and macro morality are concerned with ways of enriching relationships; macromorality through structures of society and micromorality through personal, face-to-face relationships (Rest et al., 1999). Larger issues of justice, fairness and social cooperation were addressed through the dilemma discussions and topic-specific problem-solving activities in this intervention. In this sense, families were encouraged to explore issues of macromorality at the interpersonal level.

Families read about dilemmas in which characters had to make difficult decisions and were subsequently asked to reflect on how they would have responded in this situation. During these sessions families worked together to make a decision about how they would act as a family if faced with a similar dilemma. The decision making process was challenging and dynamic for these families. Asked to consider issues of justice and fairness related to each dilemma, many of these families began to contemplate larger societal concerns in their decision making process. Furthermore, micromorality was addressed in part due to the intervention's focus on promoting ego development and relational functioning. As families participated in reflection activities, empathy exercises and tried new ways of relating with one another, they engaged in the powerful process of making meaning *together* as a systemic unit.

### *Moral Reasoning*

Moral reasoning gains were indicated for both groups on the N2 index of the DIT-2, suggesting that family therapy alone may provide some of the elements necessary to

promote developmental stage growth in the domain of moral reasoning in parents.

Results from the DIT-2 P-index provided support for the hypothesis that those families in the treatment condition would demonstrate greater gains in moral reasoning than those in the comparison group. The P-index appears to be more appropriate in assessing the level of moral reasoning for the sample in this study as their education level and pre-test means on the DIT-2 were lower than would this researcher expected. The N2 index is frequently cited as an improvement over the P-index when used with individuals at the graduate-level. The N2 index may not have been as useful for this study's sample as their modal education level was at the vocational/technical school level, and their mean P and N2 scores at pre-testing were at least half a standard deviation below the normative means. Nevertheless, both groups demonstrated gains on both indices. While the treatment group gains on the P-index were significantly greater than the comparison group, significance was not achieved to support an interaction effect (Time by Group) for the N2 index. The difference in gains is easily demonstrated, however, when one considers the effect size for each group on the N2 index. The comparison group effect size on the N2 index was  $d = .23$ , while the effect size for the treatment group on the N2 index was  $d = .49$ . Clearly, the treatment group demonstrated greater gains across both indices of the DIT-2.

Parents in the treatment group achieved significant gains in moral reasoning, and this researcher believes that the inclusion of dilemma discussion exercises specifically aimed to encourage communication and decision-making skills related to the constructs of justice and fairness were a key component in facilitating these gains. The parents who acted as participants in the treatment group actively reflected on the process of engaging in family therapy, encouraging them to make sense of their experiences as they were

happening. Some parents struggled more than others to complete the reflection exercises outside of the counseling session but were able to reflect on their experiences during their sessions. Some of the families in the treatment group faced intense financial and personal stressors and found it more difficult to engage in the often abstract task of reflecting on the experience of family counseling. Counselors found it more difficult to keep these families engaged in the process of reflecting, but also reported that reflection was possible for these families during the family sessions given adequate support. The counselors working with these families were careful to focus on the clients' immediate concerns and crises and focused on incorporating the contemplative component of the intervention into these elements of their work with the family.

One thing we know about cognitive growth is that new schemata do not replace old ones, but rather, they incorporate them, resulting in qualitative changes in the way we view the world and our place in it (Sprinthall et al., 1994). As parents tried new ways of interacting with their families, they were specifically tasked with reflecting on that process in a structured and continuous manner. The guided reflection component of this study's intervention appears to be the keystone of this approach. Counselors prompted parents to share their reflective process through the use of the reflection exercises given to each parent at the end of every session. Additionally, counselors asked parents to reflect on what they were observing during their family sessions as well as on what was observed outside of the sessions. Active, continuous and guided reflection served to provide periods of relaxed contemplation, a necessary element of the growth process when one is faced with dissonance creating experiences (Foster & Sprinthall, 1992). Parents were tasked with learning new skills, but more importantly, they were

simultaneously expected to step back from their experiences and make meaning of their new roles and expanding repertoire of adaptive tools.

While the DIT-2 is still considered an experimental instrument, this researcher feels that scores on the DIT-2 (particularly P-scores) were adequate indicators of the level of moral reasoning of parents in this study. Research on the DIT has indicated that participants are unable to “Fake High” scores, meaning that comprehension places an upper limit on the stages used in making a moral judgment (Rest et al., 1999). Individuals’ preferred level of reasoning sets the lower limit on the stages acceptable for use in moral judgment, suggesting that participants understand levels of reasoning that are less adequate even though they choose not to access those levels. Another indicator that higher scores on the DIT indicate more advanced development springs from the correlation between scores on moral reasoning and scores on other developmental scales including the WUSCT (Rest et al., 1999; Loevinger, 1998). In summary, the gains exhibited on the DIT-2 indices were likely to be accurate depictions of the participants’ shifts in the domain of moral reasoning.

The significant gains found within the treatment group provide further support for the claim that development is amenable to intervention. Developmental growth always requires giving up old ways of problem solving and creating new ways of experiencing the world; this process is inherently painful (Sprinthall, 1994). Families often struggled as they tried on new roles and ways of interacting with each other. Counselors had to provide sufficient support to these families as they navigated this process. The intervention designed for this study placed emphasis on the disequilibrating experience of counseling itself, but more importantly, it focused on extracting meaning from that



experience. Counselors were trained to deliberately promote reflection and perspective taking with their client families in order to facilitate this extraction of meaning from the family counseling experience. Careful attention was paid to providing the parents in these families with adequate levels of support and challenge as they actively “made sense” of and worked through new ways of experiencing the world. Counselors checked in with their clients and asked questions about the parents’ reactions to their new experiences. Parents were encouraged and affirmed by their counselors as they made themselves vulnerable to the change process.

The developmental shifts that occurred as a result of this study’s intervention were not surprising given that the research literature has demonstrated time and again that “active practice in problem solving related to an actual role-taking experience and augmented by interactive exchanges with others seems to speed up the natural process of psychological development with gains that are maintained and cumulative” (Evans & Foster, 2000, p. 45). Families in the treatment group participated in counseling activities that directly encouraged problem solving related to their experience both as family members and their experiences in family counseling. As the families made sense of this experience together they were able to make meaning as a collective family unit while gaining perspective on each family member’s individual viewpoint. The intense nature of family therapy acted as a catalyst to change for these families and the developmental gains that were achieved through this study occurred in a relatively short amount of time. The following section provides an overview of the length of the intervention in this study and its implications for both clinical practice and moral education initiatives.

### *Relational Functioning*

The lack of findings for the domain of relational functioning as measured by the GARF was surprising. At the onset of this study this researcher hypothesized that relational functioning would be effected by the developmental intervention, with the understanding that relational functioning would probably also increase for the comparison group. Levels of statistical significance were not achieved for the GARF, however a moderate effect size was obtained for the treatment group mean gains ( $d = .523$ ). Interestingly, the comparison group began the study with mean GARF scores nearly ten points higher than those of the treatment group. This was the most marked difference between the groups. At post-testing the comparison group appeared to trend slightly downward while the treatment group mean went up by nearly six points.

Individual counselor differences may have influenced the scores on the family's relational functioning scores and resulted in the lack of significant findings in the domain of relational functioning. Another potential, and perhaps more likely, explanation for the lack of results could be related to the diversity of the sample of families included in this study. Families who are more distressed typically score lower on the GARF and require more time in therapy to improve their situations (Ward & McCollum, 2005). The research literature has consistently pointed to the relationship between length of time in treatment and family therapy outcome, with longer amounts of time positively correlated with more favorable outcomes (Seligman, 1995). Time in treatment may have affected the potential for gains in relational functioning in this study as families only participated, on average, between four and five months. Interestingly, the length of time in treatment did not appear to affect the potential for developmental gains in this study. Perhaps, the disequilibrating and intense experience of the DPE intervention temporarily affected the participants' potential for improved relational functioning as they worked to make sense of the dissonance created through this intervention. Families in the intervention group may have felt uncomfortable in their new roles as they tried out alternative ways of

responding to their family's needs. The DPE intervention created for this study may have altered the way that families evaluated themselves, thus creating dissonance that might have influenced the families' GARF ratings. The data from this study show slight gains in relational functioning in the treatment group, while the comparison group remained relatively constant, which may simply indicate that more time was needed to demonstrate gains in relational functioning in the treatment group. Sample size undoubtedly affected the potential for significant results in this study and future studies with larger samples would be well-served to further explore the relationship between gains in development and relational functioning.

More research on the validity and reliability of the GARF needs to be completed to ensure that therapist ratings of client relational functioning are as accurate and consistent as possible. Although the counselors in this study participated in the same training procedures, variability among raters appeared to exist. Some counselors tended to rate their families higher at the start of counseling than others, perhaps as a function of their individual beliefs about client change. A client-based GARF rating form is available but has not been evaluated as reliable and was thus not used in this study. This form asks families to rate themselves and creates a client-based GARF score. Including some form of client-based rating of perceived relational functioning would be useful in future research.

### *Length of Intervention*

Ward and McCollum (2005) examined the relationship between the length of time in therapy and family therapy outcome and found results consistent with previous research on length of time in treatment and therapy outcome: the longer clients are engaged in therapy, the more likely they are to have a positive outcome. While the study did not specifically look at psychological development it suggests that, in traditional therapy, positive outcomes are linked to the length of time in treatment. Interestingly,

Ward and McCollum's study found that clients seen as few as two times showed positive outcomes in therapy, and a few families who were seen more than twenty times showed no improvement suggesting that "more sessions are not necessarily indicative of better outcomes, and fewer sessions do not always lead to poorer outcomes" (p. 218). These findings are in stark contrast to the developmental literature, which implies that more time is almost always necessary when developmental gains are the outcome given that growth in this domain is protracted (Foster & McAdams, 1998). The results of this study suggest that developmental growth in the domains of moral reasoning and ego development can be facilitated in four to five months, a relatively short amount of time. Implications of this finding are important given the constraints imposed upon families and their therapists in managed care situations. Most families coming to therapy are not afforded the luxury of an indefinite amount of free therapeutic services. The results of this study seem to suggest that significant developmental shifts can be facilitated in a relatively short time span if certain conditions are laid out in the therapeutic environment. The intervention designed in this study carefully constructed a therapeutic environment in which the five elements of Deliberate Psychological Education were emphasized: a significant role-taking experience, a balance between action and reflection, continuous, guided reflection, a balance between action and reflection and continuity of experience.

Since developmental growth progresses in an invariant and hierarchical sequence, the gains in moral reasoning and ego level are likely to be maintained over time. If, in fact, these changes are sustained, the implications of using a developmentally focused intervention in counseling become even greater. This new approach to working with families may facilitate long-term growth over the course of just 8-12 sessions, which it

appeared to demonstrate in this study. The developmental literature suggests that stage growth typically takes at least 6-9 months and yet the average amount of time families spent in therapy in this study was between four and five months. The findings of this study imply that the facilitation of stage growth may be uniquely suited to the intense, personally relevant, relational context of family therapy. The families in this study represented a wide range of income and education levels, family constellations and presenting struggles. The diverse sample of families included in this study suggests the versatility of the designed intervention. The intervention in this study focused heavily on reflection, dilemma discussion exercises and specific activities related to perspective taking and issues of justice and care. These unique features appeared to provide enough of a disequilibrating experience for the families in this study to facilitate stage growth in a short amount of time. The sample in this study was relatively small, and more research is needed to examine the effects of this type of intervention on larger samples.

### *Limitations*

Outcome research in family therapy is a complex undertaking. In many ways, this study acted as a form of outcome research in that levels of moral reasoning, ego development and relational functioning were expected to increase as a result of the implemented intervention. This study attempted to address whether or not a DPE intervention implemented in the context of family therapy was effective in increasing parents' moral reasoning, ego development and relational functioning as compared to therapy without a DPE component. Historically, efficacy studies in psychotherapy have been the "gold standard" in evaluating various treatment methods and therapy modalities (Seligman, 1995). Efficacy studies, as defined by Seligman (1995), are characterized by their highly scientific nature, which includes random assignment to groups, strictly controlled treatment conditions and manualized fixed-duration treatment. This study

incorporated certain aspects of an efficacy study; random assignment to groups, manualized treatment and videotaped sessions to address treatment integrity were included in its design.

While some conditions of an efficacy study were built into its design, this study represents an assessment of a DPE intervention in the context of real-world therapy. Seligman (1995) describes this type of research in psychotherapy as an “effectiveness” study and defines this term as research that considers how “clients fare under actual conditions of treatment in the field” (1995, p. 966). Seligman suggests that so-called effectiveness studies may be more useful in many ways than traditional efficacy studies as they include crucial elements of what is actually done in the field (1995). Through his research, Seligman has identified five properties characteristic of therapy as it is done in the field that are missing from most efficacy studies. These five properties are described below and include the non-fixed nature of the duration of therapy, that therapy is self-correcting, that clients have an active choice in the therapy and therapists they seek out, that clients present with multiple problems, and that therapy in the field is always concerned with an improvement in general functioning (1995).

The first of the five properties identified by Seligman as characteristic of real-world therapy is that therapy is not fixed in its duration. In controlled randomized trials, the length of treatment is carefully controlled, whereas in real-life clinical settings therapy is almost never fixed in its duration. While this study planned to assess families after ten sessions of the intervention, many families were tested earlier or later, and even in those families who were tested at ten sessions, the amount of time in therapy at the tenth intervention session varied greatly. The second of these properties takes into account the self-correcting nature of therapy. In efficacy studies a treatment is administered with careful attention paid to adherence to the specific treatment rather than the needs of the client. In real-world clinical settings therapy is a self-correcting process; if something does not work, something new is tried. This approach is in line with the

developmental nature of the intervention developed for this study as a DPE approach pays careful attention to constructively matching clients to meet their ever-changing needs. The flexibility inherently necessary in this type of clinical approach would not be afforded us in a traditional efficacy study. The active choice of clients in seeking out various therapies and therapists is included as the third property of therapy in the field. Clients have a choice as to the therapy they receive, and clients can refuse services. Even within this study, some clients chose not to participate in the intervention as it was explained to them. These clients were given the option of alternative services at the clinic or they were referred to outside agencies.

Next, Seligman mentions the varied and multiple problems clients present with when initiating counseling. Randomized clinical outcome studies almost always narrow their samples to include singular mental health struggles, excluding the vast majority of clients in the name of generalizability to select specific populations. Clients in therapy almost never have singular struggles, and particularly in family therapy the reasons for referral are varied and many. Finally, therapy as it is practiced in the field concerns itself with improvement in general functioning, whereas efficacy studies generally focus on specific symptom reduction or whether or not a disorder ends (Seligman, 1995). This study's aim was to increase moral reasoning, ego development and relational functioning in the family, and thus is more in line with improving overall functioning rather than providing symptom reduction. A combination of both efficacy and effectiveness research elements were included in this study; it is in this context that the threats to internal and external validity of this study are discussed below.

#### *Threats to Internal Validity*

Internal validity is related to whether or not a study's outcome is related to the variables that are measured or manipulated by the study (Gall, Gall & Borg, 2007). For the purpose of this study, several threats to internal validity were presented. This section

outlines those threats and how each threat was addressed. The first, and potentially largest threat to this study's internal validity was the high level of attrition. Attrition is common in family therapy and this researcher did not have control over the rate of dropout, however, statistical analyses were computed to determine whether differential rates of attrition existed between and within groups. This study began with thirty-nine families and ended with a total sample of  $N = 29$  participants from  $N = 22$  families. Attrition rates for this study (around 43%) were similar to those experienced generally in family therapy (as high as 50%) (Allgood, Crane & Agee, 1997). Chi-Square analyses indicated no differential rates of attrition within or between groups across all demographic variables indicating that families that dropped out of the study did not appear to be any different than those who remained in the study.

History posed a threat to this study's internal validity as the participants in both groups experienced an historic political election during the course of their therapeutic treatment. It is impossible to quantify the effect this historical event might have had on this study's participants, however, it must be noted that growth in this study might have been confounded by the social and political climate in which these participants were engaged in during this study. Maturation effects may have also confounded the results of this study. All families who completed the study experienced the effect of time; the average time spent in either of the two groups was between 4-5 months. This amount of time may have had a confounding effect on the results of this study, although the research literature does not support such a claim. Typically, developmental growth takes a long time. Prior research supports the claim that facilitating developmental stage growth, particularly for adults, takes at least six to nine months (Foster & McAdams, 1998). This



study spanned the course of two semesters; however, the average length of time spent in counseling was less than five months. Maturation effects due to time were not likely to be significant enough to promote developmental stage growth for adults. Thus, maturation may be considered as a potential, but unlikely, confounding factor related to this study's internal validity.

All three measures used presented unique challenges. The DIT-2 appears to be an improvement over the original DIT; however, more normative data need to be established to support its use across diverse samples. The Washington University Sentence Completion Test (WUSCT) poses a similar risk to this study's internal validity as it is considered a highly subjective measure whose scoring and interpretation is equally subjective. Training procedures for scoring the WUSCT are extensive; inter-rater reliability with a second rater was achieved and inter-rater reliability among the two independent raters was achieved with an expert rater. Finally, the Global Assessment of Relational Functioning requires minimal training and no procedures for establishing inter-rater reliability are laid out. While studies on the use of the GARF indicate a moderate to high level of inter-rater agreement, no specific protocols for establishing inter-rater agreement exist for use with the instrument.

This study used the same three measures at both pre and post-testing. Anytime a measurement is used repeatedly the potential for testing error becomes a reality (Gall et al., 2007). The possibility exists that participants' scores were affected by the fact that they were familiar with the instruments at post-testing. Because there was a significant amount of time between pre and post-testing, the possibility of a testing effect is

minimized, but may be considered as a potentially confounding influence on this study's results.

### *Threats to External Validity*

This study attempts to capture how a DPE intervention carried out in the context of family therapy affects parents across three areas of functioning; moral reasoning, ego development and relational functioning. A completely controlled environment is not possible in real-world therapy, and this researcher understands the limitations this places upon the generalizability of the results of this study. This section will outline threats to the external validity of this study at the population and ecological levels.

The first question to be considered when examining external validity is whether or not we can generalize from the sample included in this study to other individuals similar to those selected for this study. A convenience sample was used for the purpose of this study, as it was impossible to randomly sample all families with children exhibiting disruptive behaviors. While convenience samples do not provide the same level of generalizability as randomly selected samples, the sample in this study was carefully described so that inferences might be made as to what types of populations this study's results might be generalizable to. This researcher believes the sample selected for this study is representative of those families referred through outside agencies to counseling for issues related to the disruptive behavior of one or more children in the household. This population is a clinically significant one, as Robins and Rutter (1990) found that over 95% of families referred to family counseling were referred because of the behavioral issues of one of their children. While not a large sample ( $N = 29$ ), this study included a diverse constellation of family configurations, racial and ethnic groups, and income and education levels. The results of this study certainly should not be generalized to all families seeking counseling; however, the results of this study have important implications for general practice that may be useful across different populations of families referred to therapy for children exhibiting disruptive behaviors.

Both the treatment and comparison groups were relatively small in this study ( $n = 16$ ) and ( $n = 13$ ) respectively. The groups were examined to determine if rates of attrition were differential by group and no significant differences were found. Participants were randomly assigned to either the treatment or comparison group condition and statistical analyses indicate that both groups were relatively similar in their overall makeup.

On the ecological level, one of the greatest threats to the external validity of this study was the potential for multiple treatment interference and subsequently, adherence to treatment fidelity. To control for this threat, the treatment condition was carefully described (see Chapter Four) and videotapes of each session were kept and randomly checked to ensure specific treatment protocols were being observed. Tapes were randomly selected from the treatment group each week and were reviewed according to two criteria: adherence to that particular session's treatment objectives as outlined in the intervention timeline, and the presence of the reflective component as measured by the discussion of the reflection assignment or journal activity for that week. Of the twenty-two tapes reviewed, four (approximately 18%) were returned with suggestions on how to remediate certain aspects of the session that were not covered. The remediation process involved the counselor incorporating any missed aspects of the previous session in the subsequent session. These four tapes were returned within the first six weeks of this study's implementation. After this initial time period, tapes consistently met both criteria for adherence to treatment fidelity.

While it appears that treatment fidelity was confirmed, the nature of the counseling session does not allow for a uniform approach to working with families. The intervention designed for this study did not aim to standardize the process of counseling; it did, however, aim to provide an intentional structured element that focused on the five components of a DPE approach. This researcher feels that treatment fidelity was carefully addressed in the most thorough way possible considering the varied needs of the families who acted as participants in this study.

Another potential threat to the ecological validity of this study is the potential of a Hawthorne Effect. The counselors in this study were aware of the two treatment conditions, and may have unintentionally provided the treatment group families with more attention. As students practicing counseling in a university-based clinic, excitement about potential new treatments cannot be ignored. The potential of a Hawthorne Effect may have been mediated by the careful review of the counseling process with each family, regardless of their group affiliation, in the weekly clinical supervision process. Counselors were consistently reminded of the primary importance of meeting the family's needs as clients and because of this strong clinical focus, this researcher believes that all families in this study received similar amounts of attention.

Another potential threat to the ecological validity of this study is the possibility for experimenter effects. The counselors implementing the counseling services in this study varied in their levels of experience, gender and age. Initially two groups of counselors were kept separate, with one doctoral-level group assigned to the treatment condition and the master's level group assigned to the comparison condition. After one semester, all counselors were involved with both groups. Counselors were informed that their clients in the treatment and comparison conditions were to be treated separately. The nature of the intervention in this study allowed counselors to shift relatively easily from the treatment group families to control group families. The intervention was unambiguous and detailed, and the differences between the two groups were almost entirely based on the inclusion of specific treatment protocol for the treatment group including an emphasis on prescribed reflection exercises, and the exclusion of such exercises and treatment protocols for the comparison groups. The counselors were instructed to implement the intervention as an overall structured approach to their clinical work with clients, but were given the flexibility to attend to the needs of their clients and with their own clinical styles and preferences. Statistical analyses to examine whether there were differential treatment effects by counselor to account for this possible

experimenter effect were not possible as no one counselor had a large number of clientele. The primary researcher in this study also participated in the implementation of the intervention to provide insight, monitoring and credibility to the intervention. The primary researcher saw two families in this study. The data was examined to determine if these clients were outliers, and no evidence existed to support that these participants were any different from the other participants in the study.

### *Recommendations*

The results of this study echo the literature base suggesting that the family may be the best context for moral learning as it provides a secure framework of group identity and places children in close contact with adults who act as models for social cooperation and interpersonal connectedness (Halstead, 1999; Royal & Baker, 2005). Higher levels of development are related to more extensive resources for solving complex problems, greater ability to nurture and support, and increased flexibility and tolerance (Krumpe, 2002; Hayes, 1994; McNeel, 1994). As families navigate the complex world we live in, these tools may act as insulating factors against the inevitable transitions and stressors of modern family life. Based on the findings of this study, suggestions for further research are outlined below.

### *Longitudinal Analysis of Cognitive Development in both Parents and Children*

This study's results indicate that parents' levels of moral reasoning and ego development were significantly raised through the process of participating in family counseling with the addition of a DPE component. While this study did not measure children's levels of moral reasoning or ego development, the increase in parents' developmental levels will impact the children in these families. Additional research is needed to examine the relationship between parental development and children's

developmental shifts over time. Specifically, a study that examines longitudinally the relationship between levels of parental development and levels of children's development in the domains of moral reasoning and ego development would clarify the influence of parents on their children's development. Such research then serves to provide further support for developmental initiatives designed for parents and families.

A study in which the effects of a developmental intervention in family therapy are examined in relation to both parent and child outcomes would be equally useful. I suspect that gains in children's development would be as amenable to intervention as gains in parental development; however, I also suspect that children's developmental growth may be best studied long-term. It may take time for parents and children to fully reap the benefits of their developmental gains, although children typically demonstrate growth in shorter time periods. Since parents act as such powerful influences on their children, studying the long-term effects of developmental interventions on parents and their children would appear to be most useful. Subsequent studies might also examine how interventions similar to the one outlined in this study fare in community-based mental health agencies with counselors who are practicing, licensed professionals.

*Examination of the Effects on Counselors of Implementing Developmental Interventions*

The counselors who implemented this treatment's intervention may have been impacted by their engagement in the process of providing services aimed at increasing development. Counselor development was not measured as part of this study. I recommend a future inquiry that would examine the potential developmental gains in counselors implementing this type of intervention. This line of research might be particularly salient in counselor training programs as these counselors are themselves

assuming a new role and providing support and challenge to their clients as they are simultaneously provided support and challenge through clinical supervision. The counselors in this study were students at both the master's and doctoral level. While using student counselors posed its own unique set of challenges, this population may be more enthusiastic and open to trying new types of interventions with client populations. A future study that both replicates the current study and includes a counselor assessment component would provide useful information about the impact of these interventions on those who implement them. Specifically, counselors could be assessed using the DIT-II and the WUSCT to measure their levels of moral reasoning and ego development before engaging in the implementation of this intervention and again upon termination with the clients in the intervention. Correlations between counselor and client developmental levels at the outset of counseling should be considered as they may provide useful information about client-counselor matching and its effect on client outcome. Studying how counselors are impacted by such treatment initiatives would expand the knowledge base for both those designing developmental interventions and those who carry them out.

#### *Relational Functioning and Potential Instrument Construction*

While this intervention appeared to be successful in promoting moral reasoning and ego development gains, positive shifts in relational functioning were not great enough to be considered significant. Research is needed to examine the relationship between developmental interventions and overall family functioning. The GARF is currently one of the only assessment tools available to rate families on how they function as a unit. While clinically useful in providing the therapist with a basis for conceptualizing treatment planning, the GARF is less helpful from a research standpoint

as it is difficult to achieve consistency in inter-rater agreement. If further validation of the GARF as an assessment tool proves difficult, it may be in the best interest of family therapists to create a new kind of family rating scale that better addresses the constructs of relational functioning. Given the results of this study, I suggest a future replication of this study with the addition of another indicator of client change. The Clinical Assessment of Behavior (CAB) may help indicate client change as it measures both internalizing and externalizing behaviors of children in families referred for counseling. While the CAB would offer a quantitative measure of client change by providing data for the identified patient, this data would not provide us with a measure of relational functioning. Perhaps, future replications of this study should move away from the construct of relational functioning as an outcome indicator, and focus instead on quantifiable behavioral changes in the identified client.

### *Conclusions*

Working with parents to influence the development of their children remains an important task. The goal of this intervention was to provide families with the tools necessary to better adapt, cope and become flexible in the face of family stressors and transitions. Secondary to this aim was a focus on supporting parents as they work to build the foundational characteristics of morality in their children. Ultimately, fostering development at the parental level is aimed at the promotion of development of future generations. Parents are a powerful and primary influence on their children, and the results of this study are favorable in their implications that parental development is amenable to growth in the context of family therapy.



Research indicates that fostering growth and development in parents is, indeed an endeavor worth undertaking (Royal & Baker, 2005). This study's results suggest that moral education may well be suited for the familial context, in particular the context of family therapy. Many parents lack the opportunities for growth and development needed to promote their own moral reasoning, yet they remain important sources of influence on their children. When parents are not able to achieve higher levels of prosocial reasoning themselves, the probability of their children achieving higher levels is also threatened (Royal & Baker, 2005). Parents play important roles in providing the foundation for their children as role models through a process that is similar to scaffolding. As children grow and mature, parents support their development by offering guidance and feedback (Berkowitz & Gyrch, 1998). Royal and Baker (2005) suggest that the "time required for development to occur will be enhanced by exposure to nurturing, attentive social models" (p. 216). Fostering development in parents encourages subsequent development in children as they look to their parents for structure and guidance.

The current study suggests that, as we move forward in the field of family therapy, a more intentional focus should be placed on fostering the development of parents to create more adequate social models for future generations. Findings indicate that development both *can* and *should* be fostered in the context of relational therapy. It remains to be seen if developmental gains in moral reasoning and ego development are protective and insulating factors against future stressors for the families who participated in this study. New studies should examine the long-term effects of these types of interventions on both parents and their children. Effects on the counselors who implement developmental interventions should be explored. The lack of significant

findings in the domain of relational functioning highlights the need for replication of this study with a larger sample size, and may also suggest a need to explore whether the GARF should be used as a valid and reliable assessment tool in research. Future construction of a relational index used primarily for research purposes may prove useful to researchers in the field.

This researcher's hope is that the developmental shifts experienced by the participants in this study will be maintained over time and will provide the families who participated in this study with meaningful and adaptive resources. While the parents in this study did not demonstrate significant shifts in relational functioning over time, their relational functioning did trend slightly upward, indicating that perhaps increased family functioning was beginning to manifest itself at the time of post-testing. The results of this study call on us as counselors, educators and researchers to continue the exploration of the theoretical and clinical implications presented in this dissertation. If a developmentally focused approach to systemic therapy can provide families with more adequate tools for negotiating their unique challenges, then developmental initiatives should become a viable treatment option for families seeking support.

## Appendix A

### Informed Consent

I, (print name here) \_\_\_\_\_, am willing to participate in a study of families receiving family counseling at New Horizons Family Counseling Center.

I understand that this study is being conducted by Esther N. Benoit, a doctoral candidate in counseling at the College of William and Mary.

As a participant in this study, I am aware that I will be asked to complete research instruments at three separate times: at the beginning, middle and end of my participation in family counseling. The research instruments are: the Defining Issues Test (DIT-2); the Washington University Sentence Completion Test (SCT); the Global Assessment of Relational Functioning (GARF); and a brief demographic questionnaire.

I am aware that my participation is voluntary and that I may withdraw from this study at any time without penalty. The assessments and demographic questionnaire will be confidential and identified by a code that I will choose for instrument matching purposes. No identifying information will be reported in the study results. If I wish to discontinue participation in the study I am aware that family counseling services will still be made available to me.

I also understand that a copy of the results of the study will be given to me upon request. I am aware that I may report dissatisfactions with any aspect of this research project to the Chair of the Protection of Human Subjects Committee.

By participating in this study, I understand that there are no obvious risks to my physical or mental health.

#### Confidentiality Statement

As a participant in this study, I am aware that all records will be kept confidential and my name will not be associated with any of the results of this study.

If I have any questions that arise in connection with my participation in this study, I should contact Dr. Victoria Foster, the chair of Mrs. Benoit's Doctoral Committee at (757) 221-2321 or vafost@wm.edu. I understand that I may report any problems or dissatisfaction to Dr. Thomas Ward, chair of the School of Education Internal Review Committee at (757) 221-2358 or tjward@wm.edu or Dr. Michael Deschenes, chair of the Protection of Human Subjects Committee at the College of William and Mary at (757) 221-2778 or mrdesc@wm.edu.

**The investigator in this study may be reached by contacting Esther Benoit, (757) 221-2363, enbeno@wm.edu.**

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**Participant's Signature**

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**Date**

*Appendix B*

Below you are asked to give your ideas on a variety of topics. There are no right or wrong answers, so give your own ideas and opinions about each topic. Indicate the way you really feel about each topic, not the way others feel or the way you think you should feel. Please complete the following sentences:

- 1. Raising a family...**
- 2. A man's job...**
- 3. The thing I like about myself is...**
- 4. What gets me into trouble is...**
- 5. When people are helpless...**
- 6. A good father...**
- 7. When they talked about sex, I...**
- 8. I feel sorry...**
- 9. Rules are...**
- 10. Men are lucky because...**
- 11. At times she worried about...**
- 12. A woman feels good when...**
- 13. A husband has a right to...**
- 14. A good mother...**
- 15. Sometimes she wished that...**
- 16. If I can't get what I want...**
- 17. For a woman a career is...**
- 18. A woman should always...**

**Female Version**

**Appendix B cont.**

Below you are asked to give your ideas on a variety of topics. There are no right or wrong answers, so give your own ideas and opinions about each topic. Indicate the way you really feel about each topic, not the way others feel or the way you think you should feel. Please complete the following sentences:

- 1. Raising a family...**
- 2. A man's job...**
- 3. The thing I like about myself is...**
- 4. What gets me into trouble is...**
- 5. When people are helpless...**
- 6. A good father...**
- 7. When they talked about sex, I...**
- 8. I feel sorry...**
- 9. Rules are...**
- 10. Men are lucky because...**
- 11. At times he worried about...**
- 12. A woman feels good when...**
- 13. A husband has a right to...**
- 14. A good mother...**
- 15. Sometimes he wished that...**
- 16. If I can't get what I want...**
- 17. For a woman a career is...**
- 18. A man should always...**

**Male Version**

## Appendix C

### Dilemmas for Session #4

(HS: High School; ES: Elementary School; MS: Middle School)

#### **Darren (HS)**

Darren is a transfer student in his sophomore year in high school. By November, he had made some good friends through his soccer team and classes, but still felt on the outside of the more popular students. He has a great relationship with his mom, and trusts her advice to just give it time.

The first weekend of Thanksgiving break, rumors started that a blow out party was happening at a sophomore's house while the parents were out of town. Darren didn't know the girl well but she was one of the most popular girls in the class and most of the upperclassmen were planning on attending, as well. One of the hottest junior girls had already asked him if he would be there. Everyone was saying this was going to be the best party of the year. This seemed like the perfect opportunity to break out of his small group of friends and hang out with the students everyone always talked about. There was no way his mom would let him go to this party if she knew the parents were out of town, and he wanted to go very badly. What would you do?

#### **Lea (MS/HS)**

Lea is a member of a local theater group in a nearby city. Lately there has been talk going around that some members have been exempt from auditions for the last few productions. Leah knew in the "real world" that can happen sometimes. Some productions have such huge numbers of applicants and so little time that the more experienced, well known actors and singers sometimes get bumped up into the cast without having to try out. But, this wasn't Broadway, this was a local teen theater group and the whole idea was to give everyone a chance to prove him or herself. She and her friends talked about the rumor and how, if it was true, how unfair it was. It's one thing to know someone probably deserves to be cast in the production, but another to just put that person in without letting others compete for the same role.

The first week of tryouts for the next musical production Lea was called into the director's office. He told her she was in for one of the main singing parts. She was ecstatic at first. It was the role she had wanted more than any other. It was a starring spot and would set her up for amazing roles in the future. Then, she realized the director meant she didn't have to audition. He explained that they simply didn't have enough time to see every performer's audition. They knew her work and knew she was right for the role.

Lea was conflicted. What would she say to her friends? How would she explain this to them? She decided she would raise the question to the head director before she left his office. She asked, "What do I tell the rest of the cast?" He replied, "They don't need to know. This is often done with the strongest performers. Just skip the audition and we'll take care of the rest." What would you do? Would you talk to your parents about this if you were in Lea's place? What do you think they would do? Would you agree?

### Appendix C cont.

#### Hannah (ES/MS)

Hannah was caught cheating on her math quiz. She had been doing poorly in math and her parents had threatened that if she didn't raise her grades they wouldn't let her play on the softball team. So she cheated. When the teacher asked her about it, she denied it at first, but finally admitted to writing down the answers ahead of time.

A parent conference was called and Hannah had to sit with her parents, the teacher, and the principal to discuss the school policy on cheating and lying. On the way home, her father told Hannah he was deeply disappointed in her and expected more from her in the future. That night, she felt like the whole world was against her, but she also felt guilty for letting her parents down.

That weekend, Hannah and her family went to a movie. When they got to the ticket window Hannah's dad asked for children's tickets for both Hannah and her 16 year old brother. Hannah looked over at her brother, who stared down at the sidewalk and hunched his shoulders hoping the ticket seller wouldn't notice that he was above the age for a child's ticket. The ticket seller glanced suspiciously back and forth between the father and the brother, and then, with a doubtful look on her face, she handed them the two child's tickets. How do you think Hannah felt in this situation? How is what Hannah's father did different from what Hannah did? Have you ever felt like doing the "wrong thing" because you felt like it was worth it? What would you do in this situation?

#### Sam (ES)

Sam knew something was weird the second he got to class on Tuesday morning. He saw kids whispering and pointing at him. Some were looking at him funny. He sat down next to his best friend and picked up the graded report the teacher, Mr. Crosby, had graded over the weekend. Sam looked at the "A-" and forgot about the rest of the class for a minute. He had worked hard at that report and was thrilled it had paid off. He looked up and saw a bunch of kids staring at him. Sam whispered to Dylan, "What's going on?" Dylan, looked down and said quietly, "Conner told everyone you copied your report from the internet." "But, that's a lie!" Sam said. "I never cheat and everyone knows it." He was hurt and angry. He couldn't focus the rest of the morning in class.

At recess he went up to Conner and asked him if he had really told everyone he had cheated. "It's no big deal," Conner scoffed. "I only told a few people. Lighten up. It was just a joke." Sam turned and walked away. He wanted to yell at Conner, or hit him, or something. He just wanted to make Conner feel as bad as Conner had made him feel.

For the next two days, Sam avoided Conner but Sam and Dylan made up as many lies as they could think of about Conner to get back at him. They told kids that he was jealous of anyone who did well in school because he almost failed fourth grade last year. They told the girl Conner liked that he still wet his bed sometimes.

On Friday, Mr. Crosby had all three boys stay to talk with him during recess. He told them they had until the end of recess to work out whatever it was that was going on between them. If they had not all forgiven each other by the end of recess, they had to go to the principal's office. Then Mr. Crosby left the classroom.

The three boys stared angrily at each other waiting for someone to say something. Sam didn't know what to say. All he knew was that he was tired of being mad and hurt. What would you do?

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